

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment including the right to be fully informed in a language that he or she could understand of his or her total health status, including but not limited to, his or her medical condition for 1 of 12 resident (Resident #17) reviewed for resident rights. The facility failed to ensure Resident #17 was provided care and services in her primary language, which was Spanish. This failure could place residents at risk for not being informed of health status. Findings included: Record review of Resident #17's face sheet, printed 03/25/24, indicated Resident #17 was [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included wedge compression fracture of first lumbar vertebra (this fracture usually occurs in the front of the vertebra, collapsing the bone in the front of the spine and leaving the back of the same bone unchanged, which results in the vertebra taking on a wedge shape), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (the person does not recognize everyday social cues, both verbal and non-verbal), vascular dementia (is caused by a range of conditions that disrupt blood flow to the brain and affect memory, thinking, and behavior), mild, with agitation, and generalized anxiety disorder (excessive, ongoing anxiety and worry can interfere with your daily activities). Resident #17's preferred language was Spanish; Castilian and religion was Catholic. Record review of Resident #17's admission MDS assessment, dated 02/06/24, indicated Resident #17's preferred language was Spanish and needed or wanted an interpreter to communicate with a doctor or health care staff. Resident #17 was understood and understood others. Resident #17 had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #17 had a Mood score of 15 (moderately severe depression) out of 27 related to being bothered by certain problems and the frequency of the being bothered. Resident #17 activity preference was somewhat important regarding keeping up with news and participating in religious services or practices. Resident #17 was dependent for putting on footwear, lower body dressing, and toilet hygiene, maximal assistance for shower/bathe self, moderate assistance for oral hygiene and upper body dressing, and supervision for personal hygiene. Resident #17 was dependent for toilet transfer, chair/bed-to-chair transfer, and sit to stand. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0552 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #17's care plan, dated 01/31/24, edited 02/16/24, indicated Resident #17 did not speak in the dominant language of the facility. Language Spanish. Interventions included if a family member or friend is present that speaks/understands language, get permission to call them when needed, provide education for safety awareness, provide visual cueing with communication board, interpreter to enhance communication, and redirect resident as needed and reiterate safety awareness using communication board and interpreter. Record review of Resident #17's care plan, dated 01/31/24, edited on 03/19/24, indicated ADLs Functional Status/Rehabilitation Potential: About Me, My name is [Resident #17], I speak only Spanish and I can understand some English. I [Resident #17] do use a communication board to communicate with the staff. But I'm confused due to Dementia and at times and have trouble using the communication board, so I will use an I-Pad for google translate. Record review of Resident #17's progress notes, printed 03/25/24, indicated: On 02/05/24 at 11:44 p.m. by LVN CC, .Resident [#17] sitting up in bed this shift .language barrier continues to inhibit communication this shift .Resident [#17] able to verbalize some needs On 02/09/24 at 10:37 p.m. by LVN CC, .Resident [#17] lying in bed this shift .language barrier continues to disrupt communication between resident and staff On 02/10/24 at 10:21 p.m. by LVN CC, .Resident [#17] lying in bed this shift .language barrier continues to disrupt communication between resident and staff On 02/17/24 at 9:40 p.m. by LVN U, .Resident [#17] is usually very anxious in the evenings .this evening, resident was at the nurses station asking about getting on the bus .communication deficit due to resident [Resident #17] knowing only little English .Unable to understand exactly what resident [Resident #17] is asking .all attempts to calm and redirect unsuccessful until resident's anti-anxiety meds start to work. On 02/19/24 at 1:28 a.m. by LVN U, .all attempts to collect UA have been unsuccessful thus far .resident [Resident #17] refusing in and out cath due to language barrier On 02/19/24 at 10:41 p.m. by LVN CC, .Resident [#17] continues to engage in attention seeking behaviors . continues to self-transfer down onto floor for attention .communication continues to be strained this shift due to resident speaks fluent Spanish only On 02/20/24 at 10:43 p.m. by LVN CC, .Resident [#17] continues to engage in attention seeking behaviors . continues to self-transfer down onto floor for attention .communication continues to be strained this shift due to resident speaks fluent Spanish only On 02/21/24 at 9:50 p.m. by LVN U, .Resident [#17] has been more confused, anxious, and agitated thus far this shift .call placed to resident's daughter so that she could speak Spanish .Resident [#17] is starting to settle down at this time On 03/02/24 at 1:38 p.m. by LVN J, .patient [Resident #17] found lying on stomach on floor next to bed .very difficult to communicate with patient due to her speaking only Spanish (continued on next page)		

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F 0552 Level of Harm - Actual harm Residents Affected - Few	On 03/18/24 at 7:41 a.m. by LVN E, resident [#17] noted with bruising/ swelling to left knee and x2 abrasion . resident unable to tell staff what happened related to language barrier During an interview on 03/26/24 at 8:58 a.m., LVN E said they communicated with Resident #17 with google translator on their phone or the iPad tablet and tried to understand what she tried to say. During an interview and observation on 03/26/24 at 9:00 a.m., the facility's iPad was used to interview Resident #17 When Resident #17 was asked questions that required more than a yes or no response, she could not be understood. The google translator app did not have the capability for Resident #17 to speak Spanish into the microphone and translate to English Resident #17 could not be interviewed without an interpreter. During an observation on 03/27/24 at 11:34 a.m., Resident #17's room had a sign posted that read Call Before You Fall on the wall in English. Attempted an interview on 03/27/24 at 5:01 p.m. and 5:03 p.m., with LVN U by phone, were unsuccessful. Calls were cancelled and messages were left. There was no returned call before or after exit. During an interview on 03/27/24 at 9:59 p.m., Resident #17's family member said this was Resident #17's second time at the facility. She said Resident #17 was currently admitted at a local hospital because she felt like something was not right. She said about a week after Resident #17 was admitted to the facility, the facility provided her with an iPad with google translator. She said she saw some staff using it but there was the problem with staff understanding what Resident #17 said back to them. She said she did not feel like the facility cared to use the communication tools or get to know Resident #17. She said this admission was the worst experience with staff trying to understand Resident #17. She said she never saw the staff use the communication board with Resident #17. She said yesterday (03/26/24) she saw the communication board on Resident #17's closet floor. She said the facility needed a translator machine for the residents whose primarily language was not English. She said there was one staff member in therapy who spoke Spanish, but she had not seen him in a while. She said she expected the same care for her family member even if Resident #17 was a different race. During an interview on 03/28/24 at 8:40 a.m., LVN E said she used the Google translator or whoever spoke Spanish in the building to help her understand Resident #17. She said she did not know about a communication board to use to with Resident #17. During an interview on 03/28/24 at 9:13 a.m., CNA K said most staff spoke to Resident #17 in English. He said Resident #17 replied appropriately to yes and no questions. He said anything else besides yes or no answers, staff had to decipher what she tried to say. He said he had not seen staff use the iPad or communication board to talk to Resident #17. He said it was important to have communication tools to help understand Resident #17's want and needs. He said he never saw Resident #17 watch television or do activities. He said it would be important for the activities to be in Resident #17's preferred language. He said there used to be another resident who spoke Spanish, Resident #17 hung out with, but she was discharged recently. He said Resident #17 normally sat at the table alone with her cell phone. (continued on next page)		

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F 0552 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/28/24 at 9:15 a.m., the Interim DON said staff should be using goggle translator, staff who spoke Spanish, or contacted Resident #17's family members to translate. She said at nighttime when there was less staff available to translate, Resident #17's family did visit at night a lot. She said Resident #17 should have a communication board and staff using it. She said she did not expect the communication board to be in the floor in the closet partially under clothes. She said Resident #17's fall sign should be in Spanish. Attempted interview on 03/29/24 at 9:31 a.m., with LVN CC by phone was unsuccessful. A message was left. During an observation on 03/29/24 at 9:34 a.m., revealed in Resident #17's room was a posted activity calendar and Call Before You Fall sign on the wall in English. In Resident #17's closet floor, partially concealed by a bag of briefs and clothes, was an 8x10 laminate sheet with pictures and words in English was noted (communication board). During an interview on 03/29/24 at 11:01 a.m., CNA A said she worked with Resident #17 often. She said it was hard to communicate with Resident #17 because of the language barrier and mumbling. She said she never saw staff use the iPad or communication board to communicate with Resident #17. During an interview on 03/29/24 at 11:45 a.m., LVN J said communicating with Resident #17 was frustrating for her and the resident. She said Resident #17 answered simple questions that only required yes or no responses. She said Resident #17 had to gesture with her hands where she had pain, when asked. She said she tried to use a translator or got staff to help her talk to Resident #17. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected staff to use the communication tools the facility provided for Resident #17 which were the communication board, iPad with Google translator, or Spanish speaking staff members. She said she expected staff to let her know if the communication tools were not working for Resident #17. She said she expected signs and activities to be in the resident's preferred language. She said she had given the AD an in-service on providing activities in the resident's preferred language. She said it was the facility's responsibility to find ways to effectively communicate with Resident #17. She said Resident #17's needs needed to be met. During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said staff should use the communication tools provided to communicate with Resident #17. He said staff should notify management if the communication tools were not working. He said it was the facility's responsibility to improve or maintain a resident's ADLs. (continued on next page)		

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F 0552 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's Translation and/or Interpretation of Facility Services policy, revised 06/2020, indicated .this facility's language access program will ensure that individuals with limited English proficiency shall have meaningful access to information and services provided by the facility .the types of language access services provided by this facility shall be determined by the following factors .the size of the eligible LEP population served by the facility .the frequency .the nature and/or importance of the information or service .the resources available .all LEP person shall receive a written notice in their primary language of their rights to obtain competent oral translation services free of charge .competent oral translation of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner .a staff member who is trained and competent in the skill of interpreting .a staff interpreter who is trained and competent in the skill of interpreting .contracted interpreter service .voluntary community interpreters who are trained and competent in the skill of interpreting .telephone interpretation service . interpreters and translators must be appropriately trained in medical terminology .family members and friends shall not be relied upon to provide interpretation services for the resident unless explicitly requested by the resident .it is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 12 residents reviewed for abuse. (Resident #19) 3/23/24 Facility failed to prevent LVN BB from verbally abusing Resident #19. LVN BB told Resident #19 that no one liked her causing the resident emotional and mental anguish. This failure could place residents at risk of a diminished quality of life and psychosocial harm. Finding Include: Record review of Resident #19's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE], with diagnoses that included: Vascular Dementia (brain damage caused by multiple strokes), Senile degeneration of brain (a decrease in cognitive abilities or mental decline) and Depression (a common mental disorder). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #19 usually understood and usually understood others. The MDS assessment indicated Resident #19 had a BIMS score of 5 which indicated her cognition was severely impaired. The MDS assessment indicated Resident #19 required total assistance with ADL's. Record review of the most recent care plan dated 3/20/2024 indicated Resident #19 did not use her call light at night, but instead she would bang on her bedside table, and it kept her roommate up at night. Staff encouraged Resident #19 to use her call light when she needed assistance. Staff reminded Resident #19 that she disturbed her roommate and others when she banged on the bedside table. During an interview on 03/25/2024 at 10:08 AM Resident #19 said there was a lady staff member that was mean to her 03/23/2024 night about 11:00 PM. Resident #19 said the staff member told her No one likes you. She said she cried all night because of what the staff member had said to her. Resident #19 said she asked the staff member if she could get her a Twinkie out of her drawer because she was hungry. Resident #19 said the staff member told her All you want to do is sit up in bed all night and eat. Resident #19 said after the staff member gave her the Twinkie the staff member said there was nothing else she could do for her. Resident #19 said she did not know the staff member's name that was mean to her. Resident #19 said the staff member worked the night shift and she worked 03/24/2024. Resident #19 said she reported the incident to a family member (Family Member #2). During an interview on 03/25/24 at 3:27 PM Resident #19's family member, Family Member #1, said Resident #19 told her today a lady staff member that worked nights was rude to her. Family Member #1 said Resident #19 said the lady staff told her nobody in the facility liked her and when she asked for a Twinkie the lady smashed it before she handed it to her. Family Member #1 said Resident #19 described the lady had mid length loose curled blond hair with a nice built body. Family Member #1 said she really did not know if the incident was real or was a dream, but Resident #19 was very upset about the incident. Family Member said she notified the facility today before she left. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/25/24 at 3:39 PM the ADM was notified of the incident about Resident #19 from the state surveyor. The ADM said she was made aware of the incident earlier that day and was working on the investigation. During an interview and observation on 03/27/24 at 8:50 AM revealed Resident #27 (Resident #19's roommate) was lying in bed. Resident #27 said she remembered that around 11:00 PM or 12:00 AM on 03/23/2024 there was an incident with Resident #19 and an unknown staff. Resident #27 said Resident #19 and the unknown staff were both yelling, and she did not hear anything about a Twinkie. Resident #27 said she heard the unknown staff tell Resident #19 nobody likes you. Resident #27 said she tried to tune Resident #19 and the unknown staff out when they were yelling. Resident #27 said she was not sure what the unknown staff member's name was that said that to Resident #19, but she was a night staff member. Resident #27 said she thought the lady was a nurse because she gave medicine, and she was over the staff at night. During an interview on 03/27/24 at 9:25 AM LVN BB said she answered Resident #19's call light. LVN BB said Resident #19 wanted to be changed and wanted her Twinkie out of her drawer. LVN BB said she asked Resident #19 which one she wanted her to do first. LVN BB said Resident #19 said she wanted the Twinkie first because she had not eaten supper. LVN BB said she told Resident #19 there was no reason for her to be hateful to her. LVN BB said she was just trying to help her. LVN BB said she gave Resident #19 a Twinkie in her hand after she unwrapped it for her. LVN BB said I did not smash the Twinkie. If it was smashed it was because it was smashed in her drawer. LVN BB said she never told Resident #19 she was the most disliked Resident in the facility. LVN BB said a CNA had already given Resident #19 a Twinkie from her drawer earlier. LVN BB said a CNA came in and changed Resident #19 immediately after she left Resident #19 room. LVN BB said she did not know the CNA's name who worked with her Saturday night. During an interview on 03/28/24 at 7:41 AM Resident #19's family member, Family Member #2, said when she got to the facility on [DATE] around 11:30 AM, Resident #19 was crying and very upset. Family Member #2 said Resident #19 said someone told her she was the most disliked resident in the building. Family Member #2 said Resident #19 started crying uncontrollably again. Family Member #2 said Resident #19 said she was hungry, and she could not sleep so she got the nurse to get a Twinkie out of her drawer and smashed it, then handed it to her. Family Member #2 said Resident #19 was so upset and crying uncontrollably. Family Member #2 said Resident #19 said the woman that hurt her feelings usually came in her room at night. Family Member #2 said Resident #19 said after she asked the lady for Twinkie the lady told her all she did was sit up and eat. Family Member #2 said Resident #19 said after the lady had given her the Twinkie, she said there was not much more she could do for her. Family Member #2 did not notify the facility of the incident. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/29/24 at 9:27 AM the Interim DON said the surveyor notified the facility of the incident on Monday 3/25/2024 with Resident #19 by LVN BB. The Interim DON said after she was notified of the incident, a head-to-toe assessment was performed by the treatment nurse. The Interim DON said there were no issues with LVN BB prior to the incident. The Interim DON said the facility terminated LVN BB on 3/27/24 because she felt the nurse was rude during her interview with her. The Interim DON said Social Services met with Resident #19 to assess her. The Interim DON said the facility performed safe rounds with residents that were cared for by LVN BB. The Interim DON said Resident #19 had not reported any issues with LVN BB prior to the incident. The Interim DON said LVN BB was a blunt and to the point type of nurse. The Interim DON said Resident #27 was Resident #19's roommate and she verified the allegations, when interviewed, said she heard the staff member statement, of LVN BB saying nobody liked Resident #19 in the facility. During an interview on 03/29/24 at 10:17 AM the Interim ADM said the following actions were taken after the incident with Resident #19 and LVN BB: LVN BB was suspended during the investigation, then the facility terminated her Wednesday 3/27/2024. The Interim ADM said the facility performed safe rounds with residents to ensure no other residents were affected and terminated LVN BB for verbal abuse. Record review of the Abuse Policy dated 3/26/2024 indicated the following: Verbal abuse includes: Any use of talking inappropriately about a resident when she can hear, such as making jokes about her or calling her names.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of resident property and establish policies and procedures to report and investigate such allegations, for 2 of 17 residents (Resident #38, Resident #50), reviewed for abuse/neglect. The facility failed to ensure the ADM/Abuse Preventionist, followed the facility's policy to report an allegation of neglect for Resident #50 within 2 hours when she was found on the floor on 2/28/24 resulting in an elbow and pelvic fracture. The allegation of neglect was not reported to HHSC until 3/25/24. The facility failed to ensure the ADM/Abuse Preventionist, followed the facility's policy to report an allegation of abuse on 03/09/24, toward Resident #38 by CNA S within 2 hours of the allegations. The allegation of abuse was not reported to HHSC until 03/11/24. The facility failed to immediately remove the alleged perpetrator, CNA S from caring for Resident #38 until an investigation was completed on 03/09/24, per the facility's Abuse policy. These failures could place residents at risk of abuse, neglect, and decrease quality of life. Findings included: Record review of the facility's Abuse Prevention Program policy dated 4/8/21 indicated: Policy: The objective of the Abuse policy is to comply with the seven-step approach to abuse, neglect and exploitation detection and prevention. The Abuse policy will be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance and Performance Improvement program . Overview of the Seven Components: Prevention Screening Identification Training Protection Reporting/Responding (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation . 5. Protection Component: Abuse Policy Requirement: It is the policy of this facility that the rights will be protected of alleged victims of abuse, neglect, misappropriation or mistreatment, as well as the rights of staff who are accused of abuse, neglect misappropriation, or mistreatment - as well as those who report it. Procedures: The alleged perpetrator will immediately be removed from the resident and the resident will be protected. The resident will be assessed, examined (if necessary) and interviewed to determine any injury and clinical interventions needed, and MD and family will be notified. A medical, evidentiary or sexual assault exam will be completed if necessary. Follow-up counseling will be made available if needed . 6. Reporting/Responding component: Abuse policy requirement: It is the policy of the facility to respond to all abuse, neglect, misappropriation of property of residents, and mistreatment of residents immediately. Care and attention will be given utmost priority to the resident involved in the incident. It is also the policy of the facility to report all reportable incidents as identified by State and Federal guidelines. Upon receiving an allegation of abuse committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty. The supervisor on duty will immediately notify the Abuse Prevention Coordinator or Designee. The Alleged perpetrator will be asked to leave the facility, if onsite and if an employee will be suspended pending a full investigation. The alleged perpetrator may not return to the facility or on property until notified by the Administrator. Record review of the facility's Mandatory Notifications policy dated 2/25/23 indicated: As a requirement of the Abuse Prevention Program, employees must immediately notify the Facility Administrator and DON if any of the following events occur. This list is not all inclusive - when in doubt, make the call. Resident: Injuries of unknown origin (including skin tears, bruises, fractures) Resident altercation with or without physical injury Fracture with or without hospitalization Misappropriation/theft of resident property Drug diversions/theft of drugs/missing narcotics Stage 2, 3, or 4 acquired pressure areas (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elopement with or without injury Equipment related injury (injured using Hoyer, for example) Resident with Suicidal ideations, suicide attempt Medication/lab errors requiring hospitalization A death under unusual circumstances (choking, homicide, overdose, suicide, drowning, exposure to weather, fire, etc) Abuse/sexual assault allegation. 1.Record review of the undated face sheet revealed Resident #50 was an [AGE] year-old female that admitted [DATE] with diagnoses that included: Vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain), senile degeneration of the brain (severe cortical atrophy and cell loss with a high index of dementia), Type 2 Diabetes (a problem in the way the body regulates and uses sugar), pain, dementia, severe with anxiety (loss of cognitive functioning with anxiety from the confusion and disorientation). Record review of the significant change MDS dated [DATE] indicated Resident #50 had clear speech, was sometimes understood, and sometimes understood others. She had short-term and long-term memory problems. The MDS indicated she had impairment on one side of her upper extremities and required partial to moderate assistance for a sit to stand, chair to bed transfer, or toilet transfer. She had one fall since admission with a major injury. Record review of the undated care plan revealed Resident #50 had poor safety awareness and forgot limitations increasing the risk of falls related to impaired cognition, received antipsychotic medication once daily and was at risk for motor and sensory instability, postural hypotension, leading to falls, fractures, or other injuries. She had difficulty understanding others related to impaired cognition related to dementia. 2/28/24 indicated she had an unwitnessed fall in the dining area and was sent to ER. 2/29/24 indicated Resident #50 was at risk for pain and a decline in ROM with a sling on her left upper extremity related to an elbow fracture and a simple left pelvic fracture. Record review of a PIR dated 2/28/24 for Resident #50 indicated she had a fall with a fracture on 2/28/24. The date reported to HHSC was 3/25/24. The description of injury and assessment was her to back and left leg pain; left leg shorter than right leg. The report indicated she was transferred to the ER on [DATE]. The investigation summary indicated: On 2/28/24 around 8:45 AM, [LVN P] returned from rounds and saw resident sitting on the floor in the day room beside her wheelchair with her back leaning against the wall, legs straight out in front of her. [Resident #50] complained of pain to her back and left leg. LVN P notified NP and received order to send her to the ER . [Resident #50] returned around 5:00 PM from the hospital with diagnoses: left olecranon fracture (elbow fracture) and simple pelvic fracture. Follow up with MD and Tylenol #3 for pain control. Prior to fall had recent change in condition. NP ordered labs and recent medication changes. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation findings: Hospice to order a specialty wheelchair, drop seat and tilt. In-services: abuse/neglect, fall prevention specific for resident to keep in common area while awake. Follow up with orthopedic surgeon. Pain management for fractures. Record review of an Event Report dated 2/28/24 indicated Resident #50 was sitting in her wheelchair then fell in the day room. The report indicated Resident #50 had complained of back and left leg pain with abnormal alignment/left leg shorter than the right leg. Notified supervisor. Notified NP and received new order to send her to the ER. During an interview on 03/25/24 at 3:53 PM, the ADM and the DON said regarding Resident #50's fall and fracture on 2/28/24 they both said the prior DON did not report the fall to the ADM, and both agreed it was a failure to report per the abuse policy. The DON said the prior DON did not call the ADM and tell her about the fall. The ADM said she was going to report it today (3/25/24) even though it was almost a month later. The DON said an investigation was done immediately after the incident. During an interview on 3/26/24 at 7:39 AM, the ADM said she did not know about Resident #50's fall (that occurred 2/28/24) until yesterday (3/25/24) when the current DON told her. She said she was working at the facility at the time of Resident #50's fall and had worked at the facility since late November of 2023. She said normally the DON would give her the information then did all the investigations, and they would discuss it. She said that did not happen with Resident #50's fall on 2/28/24 because the prior DON did not tell her about it. She said the previous DON left 3/8/24. She said the current DON had the investigation. She said the incident should have been reported to the state right after it happened. She said it was not reported to the state within 2 hours or 24 hours because she did not report it until yesterday. She said the process regarding falls was she was supposed to be notified immediately by the DON. She said their process failed with the prior DON not informing her. She said the process was the same, but they had a different DON. She said she believed the fault was with the prior DON. She said not reporting the incident to the state could have affected all the residents. She said she looked at all incidents/events and did not see any other falls or injuries that she was not aware of or had not reported, and there were none. During an interview on 3/26/24 at 8:09 AM, the (current) DON said she knew on 2/28/24 that Resident #50 fell because the prior DON called and told her. The prior DON told her Resident #50 was in the day room and kept trying to stand up. The nurse was watching her and turned her back for a moment, and Resident #50 was in the floor. She said she told the prior DON what to do regarding investigation, in-services, etc. She said the prior DON had done in-services and an investigation. She said the ADM was in the TEAMS chat that she posted in. She said the ADM said she did not know about Resident #50's fall, but several were in the TEAMS chat (an online chat where numerous people can communicate) and the ADM was also in the TEAMS chat. She said she believed not reporting to the state was an oversite on the part of the ADM. She said We all know a fall with fracture is a reportable. She said the ADM reported Resident #50's fall yesterday (3/25/24). During an interview on 3/26/24 at 8:22 AM, the Owner of the facility said their intent was to report everything to the state that was required. He said all staff were trained to know that. He said the prior DON was terminated (2/29/24) the day after Resident #50 fell . He said that could have contributed to it not being reported. He said the ADM should have been made aware of the issue because she would have been a part of the communication process on TEAMS. He said it was an oversight on the part of the ADM that it was not reported timely. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 2:33 PM, ADON C said on 2/28/24 Resident #50 was found in the floor at the nurse's station. She said LVN P was near her or watching her. She said LVN P had stepped away for just a second to get something and when she stepped back Resident #50 was on the floor. She said LVN P was watching her because she kept trying to get up. She said Resident #50 was overly anxious that day. She said LVN P was only away from her for 3-4 minutes. She said there were other residents in the area of the nurse's station at that time but all were in their chairs. She said she did not suspect abuse. She said Resident #50 had dementia, was a frequent check resident, and she thought she may have had a UTI at the time. She said the prior DON investigated the fall. She said she did abuse in-services and things like that. She said she helped LVN P assess Resident #50 after she was found in the floor. She said they did not move her because one limb was shorter than the other, and EMS moved her. She said when a resident fell and had an injury it had to be reported to the state in 2 hours. She said the ADM usually reported to the state and the DON would help get information. She said she assumed Resident #50's fall had already been reported and she did not know it was not until yesterday. She said she did not know where the ball dropped and was surprised it did not get reported when it should have been. During an interview on 3/28/24 at 7:31 AM, LVN D said any fall with injury to the resident had to be reported to the state immediately. She said the ADM did all the reporting and they always let her know as soon as possible so she could report timely. During an interview on 3/28/24 at 7:57 AM, ADON F said all incidents of resident falls or injuries should be reported to the DON and ADM as soon as possible and they would report it to the state authority. During an interview on 3/28/24 at 7:56 AM, the DON said she believed the ADM had reported Resident #50's fall and fractures to the state because she said she talked with the ADM about it and made it clear she needed to report it to the state. She said it should have been reported in 2 hours to the state. She said the risk of not reporting it to the state was that it was possible it would not be investigated, but in this case it was. She said not reporting this incident went against the process. During an interview on 3/28/24 at 8:06 AM, the Interim ADM said Resident #50's fall with fractures should have been reported to the state within 2 hours. He said the risk of not reporting it was maybe an investigation was not done. He said he did not discuss it with the prior ADM so he was not aware if she knew about it. 44933 2. Record review of Resident #38's face sheet printed 03/25/24 indicated Resident #38 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including transient cerebral ischemic attack (is a temporary blockage of blood flow to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) affecting left non-dominant side, and muscle wasting and atrophy (shortening). (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #38's quarterly MDS assessment dated [DATE] indicated Resident #38 was understood and understood others. The MDS indicated Resident #38 had a BIMS score of 13 which indicated intact cognition. Record review of Resident #38's care plan dated 02/14/24 indicated ADLs Functional Status/Rehabilitation Potential. Intervention included Resident #38 needed assist with transfers to and from the bed to the toilet and to the shower related to hemiplegia and hemiparesis to left side. Record review of Resident #38's progress notes by LVN R dated 03/09/24 at 11:38 a.m., indicated .Resident [#38] also stated that when asked for assistance to restroom CNA [CNA S] rammed her knees into the bathroom wall while transferring Resident [#38] to the toilet .Resident [#38] states that she feel as though the CNA [CNA S] was trying to hurt her because she did not want to help her to restroom .this nurse [LVN R] spoke with CNA [CNA S] and CNA denied the statement that Resident [#38] gave .this nurse suggested either CNA [CNA S] swap Resident [#38] with the other CNA on the hall or that 2 people go into Residents [#38] room for the remainder of this shift to keep confusion down .this nurse will be making frequent checks on Resident [#38] and CNA [CNA S] interaction the remainder of this shift .Corporate in house notified . Administrator notified .statement written by both CNA [CNA S] and the Nurse [LVN R] . Record review of the facility's Provider self-reporting of LTC incidents dated 03/11/24 at 2:34 p.m., indicated . incident dated: 03/09/2024 .Time: 9:30 AM .Date Time Facility first learned of the Incident: March 10, 2024 . Time: 3:00 PM .Incident Category: Abuse . [Resident #38] reported to [LVN R] that CNA rammed her knees into the wall of the restroom while transferring . Record review of an undated and untimed investigation note by the ADM indicated .this writer was informed by [LVN R] that Resident #38 informed her that her CNA [CNA S] rammed her knees into restroom wall while transferring her to the toilet .Resident #38 informed the nurse that she felt like the CNA [CNA S] was upset and did not want to assist her to the restroom .the nurse aide [CNA S] stated she did assist the Resident [#38] to the restroom, but she denied ramming her knees into the wall .she [CNA S] informed the Nurse [LVN R] of her findings, but she had no idea that the Resident [#38] had made the allegation of abuse . Record review of an undated and untimed statement by the Interim DON (provided after entry on 03/27/24)indicated , .On 03/09/24 during rounds visited with resident [Resident #38], resident pleasant and no complaints .mentioned she had an issue this morning .she reported CNA [CNA S] took scissors and she [Resident #38] did not know why .also that the CNA [CNA S] while assisting her to the bathroom accidentally bumped knees into wall .she does not feel it was on purpose .assessed both knees no redness, bruising, or complaint of pain .asked resident [#38] if she wanted CNA [CNA S] to continue caring for her and she reported that she had been good this afternoon .on Sunday 03/10/24 afternoon, I [Interim DON] read in[electronic charting system] nurse notes that agency nurse [LVN R] documented that resident attempted suicide with scissors and CNA [CNA S] rammed knees into wall while assisting to bathroom .notified Administrator .Investigation started regarding CNA [CNA S] ramming knees . Record review of CNA S's written statement dated 03/09/24 at 7:56 a.m., indicated .I [CNA S] have to let the nurse [LVN R] know you're talking like this . she [Resident #38] stated well if you tell on me I'm going to say you are mean to me . (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN R's written statement dated 03/11/24 indicated .Resident [#38] stated that CNA [CNA S] rammed knees into restroom wall while transferring to toilet .Resident [#38] stated that she felt like CNA [CNA S] was upset and did not want to assist her to the restroom .this nurse assessed both knees, no pain voiced and no redness, skin tears or bruise noted at that time .this nurse [LVN R] interviewed CNA and CNA [CNA S] denied incident .CNA [CNA S] stated she did assist Resident [#38] to restroom but did not ram her knees into the wall .corporate nurse in house was notified .corporate nurse assessed Resident [#38] knees with no findings . Record review of an undated and untimed in-service Abuse Prevention Program indicated signature of LVN R. Record review of an in-service Abuse/Neglect facilitated by the ADM, dated 03/09/24 indicated 50 staff members signatures including LVN R and CNA S. On 03/26/24 at 2:05 p.m., The surveyors were informed by the Owner and the DON, the ADM was released from her duties and would not be returning. Unable to interview the ADM about incident. During an interview on 03/26/24 at 11:04 a.m., Resident #38 said she had been to the restroom several times already and needed to go again that day. She said it had been a bad morning that day. She said CNA S had found her in the wheelchair headed out the room not properly dressed. She said CNA S was in a hurry to get her back to bed but she had told her she needed to go to the restroom again. She said CNA S took her to the bathroom and her knee hit the wall, but it was not on purpose. She said the wheelchair got away from CNA S. She said she did not remember telling anyone CNA S hit her knee to the wall on purpose. She said CNA S had been sweet ever since and she was not afraid of her. During an interview on 03/26/24 at 4:45 p.m., CNA S said Resident #38 was upset with her because she was going to report to LVN R that Resident #38 had scissors and was stabbing her stomach with them. She said when she told Resident #38, she was going to report her she said, If you tell on me, I will say you hurt me! She said she reported Resident #38 having scissors to LVN R and later heard her on the phone with probably her family member telling him she (CNA S) rammed her knee in the bathroom. During an interview on 03/27/24 at 10:04 a.m., CNA S said she never took Resident #38 to bathroom during the time she reported her knees were rammed. During an interview on 03/27/24 at 11:27 a.m., the DOCR said CNA S saw her in the hallway and told her after breakfast, Resident #38 had scissors and would be mad she reported to her what happened. She said CNA S told her that Resident #38 would say she rammed her knee. She said Resident #38 told her CNA S took her to the restroom and bumped her knees, but it was an accident. She said she assessed her knees and did not see anything. She said she and LVN R assisted Resident #38 to the restroom after she finished talking to her. She said she left for day but called the Interim DON and told her about the incident. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/24 at 12:59 p.m., LVN R said she went to speak to Resident #38 after CNA S brought her the scissors. She said Resident #38 said CNA S was mad at her because she did not want to assist her to the bathroom. She said Resident #38 told her CNA S rammed her knees into the bathroom wall on purpose. She said she assessed Resident #38 knees and did not see any bruises. She said Resident #38 tried to call her family member and she did too, but he did not answer. She said later, her and the DOCR went to talk to Resident #38. She said Resident #38 said CNA S may have been frustrated when she took her to the bathroom and did not ram her knees on purpose. She said Resident #38 was on the light a lot that morning. She said 30 minutes prior to the incident, CNA S had gotten Resident #38 for breakfast. She said her and the DOCR took Resident #38 to the bathroom after they finished talking to her. During an interview on 03/27/24 at 1:34 p.m., the Interim DON said she went to Resident #38's room on 03/09/24 and Resident #38 said CNA S took her scissors and accidentally bumped her knee. She said LVN R did not tell the ADM, Resident #38 reported to her, CNA S purposely rammed her knees into the wall. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected allegations of abuse to be reported to the ADM immediately. She said the ADM was responsible for reporting allegations of abuse to HHSC within 2 hours of the event. She said when she notified the previous ADM on 03/10/24, that LVN R documented in a progress note that CNA S rammed Resident #38 knees with the intent to hurt her, she should have reported it. She said an investigation of the incident was started on 03/10/24, even though it was not reported to the HHSC until 03/11/24. She said not reporting to the State went against the facility's Abuse policy. She said on 03/09/24, she and CNA S went to Resident #38's room together. She said CNA S apologized to Resident #38 for any misunderstandings and Resident #38 wanted to hug CNA S. She said LVN R did not communicate to the ADM on 03/09/24 that CNA S alleged rammed Resident #38's knees on purpose. She said when the facility was aware of the allegation of abuse on 03/10/24 from LVN R's progress note, CNA S was not allowed to return until the investigation was completed. She said safe surveys were done on 03/09/24 with no complaints of CNA S. During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said he expected the staff the report abuse allegations and other mandatory events to the ADM immediately per the facility's policies. He said reporting of abuse allegations was required within 2 hours of the incident to the State. He said the ADM or abuse coordinator was responsible for reporting to HHSC. He said not reporting risked the incident not being investigated by the facility and the State. He said alleged perpetrators were supposed to be removed to protect the resident and suspended until the investigation was completed. He said staff were aware of the facility's abuse policy upon hire, annually, and after certain incidents. He said he could not comment on Resident #38's incident because he was not the ADM at that time.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observation, interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency for 2 of 17 residents (Resident #50 and Resident #38) reviewed for allegations of abuse, neglect, exploitation, and mistreatment. The facility failed to ensure the ADM/Abuse Preventionist reported the neglect allegation on 2/28/24 for Resident #50 within 2 hours when she was found in the floor resulting in an elbow and pelvic fracture. The allegation of neglect was not reported to HHSC until 3/25/24. The facility failed to ensure the ADM/Abuse Preventionist report allegation of abuse on 03/09/24, toward Resident #38 by CNA S within 2 hours of the allegations. The allegation of abuse was not reported to HHSC until 03/11/24. These failures could place all residents at increased risk for potential abuse to unreported allegations of abuse and neglect, diminished quality of life, and harm. Findings included: 1.Record review of the undated face sheet revealed Resident #50 was an [AGE] year-old female that admitted [DATE] with diagnoses that included: Vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain), senile degeneration of the brain (severe cortical atrophy and cell loss with a high index of dementia), Type 2 Diabetes (a problem in the way the body regulates and uses sugar), pain, dementia, severe with anxiety (loss of cognitive functioning with anxiety from the confusion and disorientation). Record review of the significant change MDS dated [DATE] indicated Resident #50 had clear speech, was sometimes understood, and sometimes understood others. She had short-term and long-term memory problems. The MDS indicated she had impairment on one side of her upper extremities and required partial to moderate assistance for a sit to stand, chair to bed transfer, or toilet transfer. She had one fall since admission with a major injury. Record review of the undated care plan revealed Resident #50 had poor safety awareness and forgot limitations increasing the risk of falls related to impaired cognition, received antipsychotic medication once daily and was at risk for motor and sensory instability, postural hypotension, leading to falls, fractures, or other injuries. She had difficulty understanding others related to impaired cognition related to dementia. 2/29/24 indicated Resident #50 was at risk for pain and a decline in ROM with a sling on her left upper extremity related to an elbow fracture and a simple left pelvic fracture. 2/28/24 indicated she had an unwitnessed fall in the dining area and was sent to ER. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a PIR dated 2/28/24 for Resident #50 indicated she had a fall with a fracture on 2/28/24. The date reported to HHSC was 3/25/24. The description of injury and assessment was back and left leg pain, left leg shorter than right leg. The report indicated she was transferred to the ER 2/28/24. The investigation summary indicated: On 2/28/24 around 8:45 AM, LVN P returned from rounds and saw resident sitting on the floor in the day room beside her wheelchair with her back leaning against the wall, legs straight out in front of her. Resident #50 complained of pain to her back and left leg. LVN P notified NP and received order to send her to the ER . Resident #50 returned around 5:00 PM from the hospital with diagnoses: left olecranon fracture (elbow fracture) and simple pelvic fracture. Follow up with MD and Tylenol #3 for pain control. Prior to fall had recent change in condition. NP ordered labs and recent medication changes. Investigation findings: Hospice to order a specialty wheelchair, drop seat and tilt. In-services: abuse/neglect, fall prevention specific for resident to keep in common area while awake. Follow up with orthopedic surgeon. Pain management for fractures. Record review of an Event Report dated 2/28/24 indicated Resident #50 had was sitting in her wheelchair then fell in the day room. The report indicated Resident #50 had complained of back and left leg pain with abnormal alignment/left leg shorter than right leg. Notified supervisor. Notified NP and received new order to send her to the ER. During an observation and interview on 3/25/24 at 10:49 AM, Resident #50 was sitting in her bed. She had a sling on her left arm. She said she did not know why she had the sling on her arm. She was not interviewable. During an interview on 03/25/24 at 3:53 PM, the ADM and the DON said regarding Resident #50's fall and fracture on 2/28/24 they both said the prior DON did not report the fall to the ADM, and both agreed it was a failure to report per the abuse policy. The DON said the prior DON did not call the ADM and tell her about the fall. The ADM said she was going to report it today (3/25/24) even though it was almost a month later. The DON said an investigation was done. During an interview on 3/26/24 at 7:39 AM, the ADM said she did not know about Resident #50's fall (that occurred 2/28/24) until yesterday (3/25/24) when the current DON told her. She said she was working at the facility at the time of Resident #50's fall and had worked at the facility since late November of 2023. She said normally the DON would give her the information then did all the investigations, and they would discuss it. She said that did not happen with Resident #50's fall on 2/28/24 because the prior DON did not tell her about it. She said the previous DON left 3/8/24. She said the current DON had the investigation. She said this incident should have been reported to the state right after it happened. She said it was not reported to the state within 2 hours or 24 hours because she did not report it until yesterday. She said the process regarding falls was she was supposed to be notified immediately by the DON. She said their process failed with the prior DON not informing her. She said the process was the same, but they had a different DON. She said she believed the fault was with the prior DON. She said not reporting this to the state could have affected all the residents. She said she looked at all incidents/events and did not see any other falls or injuries that she was not aware of or had not reported, and there were none. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 8:09 AM, the (current) DON said she knew on 2/28/24 that Resident #50 fell because the prior DON called and told her. The prior DON told her Resident #50 was in the day room and kept trying to stand up. The nurse was watching her and turned her back for a moment, and Resident #50 was in the floor. She said she told the prior DON what to do regarding investigation, in-services, etc. She said the prior DON had done in-services and an investigation. She said the ADM was in the TEAMS chat that she posted in. She said the ADM said she did not know about Resident #50's fall, but several were in the TEAMS chat (an online chat where numerous people can communicate) and ADM was also in the TEAMS chat. She said she believed not reporting to the state was an oversight on the part of the ADM. She said We all know a fall with fracture is a reportable. She said the ADM reported Resident #50's fall yesterday (3/25/24). During an interview on 3/26/24 at 8:22 AM, the owner of the facility said their intent was to report everything to the state that was required. He said all staff were trained to know that. He said the prior DON was terminated (2/29/24) the day after Resident #50 fell . He said that could have contributed to it not being reported. He said the ADM should have been made aware of the issue because she would have been a part of the communication process on TEAMS. He said it was an oversight on the part of the ADM that it was not reported timely. During a phone interview on 3/26/24 at 1:51 PM, Resident #50's family member said he did not believe Resident #50 had been abused. He said he believed she fell from having a UTI. During an interview on 3/26/24 at 2:33 PM, ADON C said on 2/28/24 Resident #50 was found in the floor at the nurses station. She said LVN P was near her or watching her. She said LVN P had stepped away for just a second to get something and when she stepped back Resident #50 was on the floor. She said LVN P was watching her because she kept trying to get up. She said Resident #50 was overly anxious that day. She said LVN P was only away from her for 3-4 minutes. She said there were other residents in the area of the nurse's station at that time but all were in their chairs. She said she did not suspect abuse. She said Resident #50 had dementia, was a frequent check resident, and she thought she may have had a UTI at the time. She said the prior DON investigated the fall. She said she did abuse in-services and things like that. She said she helped LVN P assess Resident #50 after she was found in the floor. She said they did not move her because one limb was shorter than the other, and EMS moved her. She said when a resident fell and had an injury it had to be reported to the state in 2 hours. She said the ADM usually reported to the state and the DON would help get information. She said she assumed Resident #50's fall had already been reported and she did not know it was not until yesterday. She said she did not know where the ball dropped and was surprised it did not get reported when it should have been. During an interview on 3/28/24 at 7:31 AM, LVN D said any fall with injury to the resident had to be reported to the state immediately. She said the ADM did all the reporting and they always let her know as soon as possible so she could report timely. During an interview on 3/28/24 at 7:57 AM, ADON F said all incidents of resident falls or injuries should be reported to the DON and ADM as soon as possible and they would report it to the state authority. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 7:56 AM, the DON said she believed the ADM had reported Resident #50's fall and fractures to the state because she said she talked with the ADM about it and made it clear she needed to report it to the state. She said it should have been reported in 2 hours to the state. She said the risk of not reporting it to the state was that it was possible it would not be investigated, but in this case it was. She said not reporting this incident went against the process. During an interview on 3/28/24 at 8:06 AM, the Interim ADM said Resident #50's fall with fractures should have been reported to the state within 2 hours. He said the risk of not reporting it was maybe an investigation was not done. He said he did not discuss it with the prior ADM so he was not aware if she knew about it. 44933 2. Record review of Resident #38's face sheet printed 03/25/24 indicated Resident #38 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including transient cerebral ischemic attack (is a temporary blockage of blood flow to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) affecting left non-dominant side, and muscle wasting and atrophy (shortening). Record review of Resident #38's quarterly MDS assessment dated [DATE] indicated Resident #38 was understood and understood others. The MDS indicated Resident #38 had a BIMS score of 13 which indicated intact cognition. The MDS indicated Resident #38 used a wheelchair for a mobility device and had upper extremity limitation in range of motion to one side of the body. The MDS indicated Resident #38 admission performance requirement was maximal assistance for putting on footwear, lower body dressing, and toilet hygiene and moderate assistance for oral hygiene, shower/bathe self, upper body dressing, and personal hygiene. The MDS indicated Resident #38 was always incontinent for urine and bowel. Record review of Resident #38's care plan dated 02/14/24 indicated ADLs Functional Status/Rehabilitation Potential. Intervention included Resident #38 needed assist with transfer to and from the bed to the toilet and to the shower related to hemiplegia and hemiparesis to left side. Record review of Resident #38's progress notes by LVN R dated 03/09/24 at 11:38 a.m., indicated .Resident [#38] also stated that when asked for assistance to restroom CNA [CNA S] rammed her knees into the bathroom wall while transferring Resident [#38] to the toilet .Resident [#38] states that she feel as though the CNA [CNA S] was trying to hurt her because she did not want to help her to restroom .this nurse [LVN R] spoke with CNA [CNA S] and CNA denied the statement that Resident [#38] gave .this nurse suggested either CNA [CNA S] swap Resident [#38] with the other CNA on the hall or that 2 people go into Residents [#38] room for the remainder of this shift to keep confusion down .this nurse will be making frequent checks on Resident [#38] and CNA [CNA S] interaction the remainder of this shift .Corporate in house notified . Administrator notified .statement written by both CNA [CNA S] and the Nurse [LVN R] . (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA S's written statement dated 03/09/24 at 7:56 a.m., indicated .I [CNA S] have to let the nurse [LVN R] know you're talking like this . she [Resident #38] stated well if you tell on me I'm going to say you are mean to me . Record review of LVN R's written statement dated 03/11/24 indicated .Resident [#38] stated that CNA [CNA S] rammed knees into restroom wall while transferring to toilet .Resident [#38] stated that she felt like CNA [CNA S] was upset and did not want to assist her to the restroom .this nurse assessed both knees, no pain voiced and no redness, skin tears or bruise noted at that time .this nurse [LVN R] interviewed CNA and CNA [CNA S] denied incident .CNA [CNA S] stated she did assist Resident [#38] to restroom but did not ram her knees into the wall .corporate nurse in house was notified .corporate nurse assessed Resident [#38] knees with no findings . Record review of the facility's Provider self-reporting of LTC incidents dated 03/11/24 at 2:34 p.m., indicated . incident dated: 03/09/2024 .Time: 9:30 AM .Date Time Facility first learned of the Incident: March 10, 2024 . Time: 3:00 PM .Incident Category: Abuse . [Resident #38] reported to LVN R that CNA rammed her knees into the wall of the restroom while transferring . Record review of an undated and untimed investigation note by the ADM indicated .this writer was informed by LVN R that Resident #38 informed her that her CNA rammed her knees into restroom wall while transferring her to the toilet .Resident #38 informed the nurse that she felt like the CNA was upset and did not want to assist her to the restroom .the nurse aide [CNA S] stated she did assist the Resident [#38] to the restroom, but she denied ramming her knees into the wall .she [CNA S] informed the Nurse [LVN R] of her findings, but she had no idea that the Resident [#38] had made the allegation of abuse . Record review of an undated and untimed statement by the Interim DON (provided after entry on 03/27/24)indicated , .On 03/09/24 during rounds visited with resident [Resident #38], resident pleasant and no complaints .mentioned she had an issue this morning .she reported CNA [CNA S] took scissors and she [Resident #38] did not know why .also that the CNA [CNA S] while assisting her to the bathroom accidentally bumped knees into wall .she does not feel it was on purpose .assessed both knees no redness, bruising, or complaint of pain .asked resident [#38] if she wanted CNA [CNA S] to continue caring for her and she reported that she had been good this afternoon .on Sunday 03/10/24 afternoon, I [Interim DON] read in Matrix nurse notes that agency nurse [LVN R] documented that resident attempted suicide with scissors and CNA [CNA S] rammed knees into wall while assisting to bathroom .notified Administrator .Investigation started regarding CNA ramming knees . Record review of an undated and untimed in-service Abuse Prevention Program indicated signature of LVN R. Record review of an in-service Abuse/Neglect facilitated by the ADM, dated 03/09/24 indicated 50 staff members signatures including LVN R and CNA S. On 03/26/24 at 2:05 p.m., The surveyors were informed by the Owner and the DON, the ADM was released from her duties and would not be returning. Unable to interview the ADM about incident. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/24 at 11:04 a.m., Resident #38 she had been to the restroom several times already and needed to go again that day. She said it had been a bad morning that day. She said CNA S had found her in the wheelchair headed out the room not properly dressed. She said CNA S was in a hurry to get her back to bed but she had told her, she needed to go to the restroom again. She said CNA S took her to the bathroom and her knee hit the wall, but it was not on purpose. She said the wheelchair got away from CNA S. She said she did not remember telling anyone CNA S hit her knee to the wall on purpose. She said CNA S had been sweet ever since and she was not afraid of her. During an interview on 03/26/24 at 4:45 p.m., CNA S said Resident #38 was upset with her because she was going to report to LVN R, Resident #38 had scissors and stabbing her stomach with them. She said when she told Resident #38, she was going to report her she [Resident #38] said, If you tell on me, I will say you hurt me! She said she reported Resident #38 having scissors to LVN R and later heard her on the phone with probably her son telling him I rammed her knee in the bathroom. During an interview on 03/27/24 at 10:04 a.m., CNA S said she never took Resident #38 to bathroom during the time she reported her knees were rammed. During an interview on 03/27/24 at 11:27 a.m., the DOCR said CNA S saw her in the hallway and told her after breakfast, Resident #38 had scissors and would be mad she reported to her what happened. She said CNA S told her; Resident #38 will say she rammed her knee. She said Resident #38 told her CNA S took her to the restroom and bumped her knees, but it was an accident. She said she assessed her knees and did not see anything. She said she and LVN R assisted Resident #38 to the restroom after she finished talking to her. She said she left for day but called the Interim DON and told her about the incident. During an interview on 03/27/24 at 12:59 p.m., LVN R said she went to speak to Resident #38 after CNA S brought her the scissors. She said Resident #38 said CNA S was mad at her because she did not want to assist her to the bathroom. She said Resident #38 told her CNA S rammed her knees in the bathroom wall on purpose. She said she assessed Resident #38 knees and did not see any bruises. She said Resident #38 tried to call her son and she did too, but he did not answer. She said later, her and DOCR went to talk to Resident #38. She said Resident #38 said CNA S may have been frustrated when she took her to the bathroom and did not ram her knees on purpose. She said Resident #38 was on the light a lot that morning. She said 30 minutes prior to the incident, CNA S had gotten Resident #38 for breakfast. She said her and DOCR took Resident #38 to the bathroom after they finished talking to her. During an interview on 03/27/24 at 1:34 p.m., the Interim DON said she went to Resident #38's room on 03/09/24 and she said CNA S took her scissors and accidentally bumped her knee. She said LVN R did not tell the ADM, Resident #38 reported to her, CNA S purposely rammed her knees into the wall. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected allegation of abuse to be reported to the ADM immediately. She said the ADM was responsible for reporting allegation of abuse to HHSC, within 2 hours. She said when she notified the previous ADM on 03/10/24, that LVN R documented in a progress note, CNA S rammed Resident #38 knees with the intent to hurt her, she should have reported it. She said an investigation of the incident was started on 03/10/24, even though it was not reported to the HHSC until 03/11/24. She said not reporting to the State went against the facility's Abuse policy. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said he expected the staff the report abuse allegation and other mandatory events to the ADM immediately per the facility's policies. He said reporting of abuse allegation was required within 2 hours of the incident to the State. He said the ADM or abuse coordinator was responsible for reporting to HHSC. He said not report risked the incident not being investigated by the facility and the State. He said he could not comment on Resident #38 incident because he was not the ADM at that time. Record review of the facility's Abuse Prevention Program policy dated 4/8/21 indicated: Policy: The objective of the Abuse policy is to comply with the seven-step approach to abuse, neglect and exploitation detection and prevention. The Abuse policy will be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance and Performance Improvement program . 6. Reporting/Responding component: Abuse policy requirement: It is the policy of the facility to respond to all abuse, neglect, misappropriation of property of residents, and mistreatment of residents immediately. Care and attention will be given utmost priority to the resident involved in the incident. It is also the policy of the facility to report all reportable incidents as identified by State and Federal guidelines. Upon receiving an allegation of abuse committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty. The supervisor on duty will immediately notify the Abuse Prevention Coordinator or Designee. The Alleged perpetrator will be asked to leave the facility, if onsite and if an employee will be suspended pending a full investigation. The alleged perpetrator may not return to the facility or on property until notified by the Administrator. Record review of the facility's Mandatory Notifications policy dated 2/25/23 indicated: As a requirement of the Abuse Prevention Program, employees must immediately notify the Facility Administrator and DON if any of the following events occur. This list is not all inclusive - when in doubt, make the call. Resident: Injuries of unknown origin (including skin tears, bruises, fractures) Resident altercation with or without physical injury Fracture with or without hospitalization Misappropriation/theft of resident property Drug diversions/theft of drugs/missing narcotics (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 2, 3, or 4 acquired pressure areas Elopement with or without injury Equipment related injury (injured using Hoyer, for example) Resident with Suicidal ideations, suicide attempt Medication/lab errors requiring hospitalization A death under unusual circumstances (choking, homicide, overdose, suicide, drowning, exposure to weather, fire, etc) Abuse/sexual assault allegation.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interviews and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 17 residents (Resident #56) reviewed for MDS assessment accuracy. The facility failed to code Resident #56's diagnosis of Schizophrenia on her MDS. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #56's face sheet dated 3/27/2024 revealed she was a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #56 had diagnoses of Charcot's joint, right ankle, and foot (a disease that attacks the bones, joints, and soft tissue of feet), Acute osteomyelitis, right ankle, and foot (an infection in a bone), Diabetes Mellitus (group of diseases that affect how the body uses blood sugar) and anxiety disorder due to known physiological condition (frequent intense, excessive, and persistent worry or fear about everyday situations). Record review of Resident #56's Comprehensive MDS dated [DATE] indicated Resident #56 had a BIM's score of 13 indicating she was cognitively intact. Resident #56 understood others and was able to be understood by others. The MDS indicated Resident #56 had a diagnosis of non-Alzheimer's Dementia and anxiety. Record Review of Resident #56's care plan dated 3/18/2024 indicated the resident had potential for dehydration related to diagnosis of dementia and diuretic use. During an interview on 3/27/2024 at 11:35 a.m., Resident #56 said she did not have a diagnosis of dementia. Resident #56 said the psychiatric out-patient clinic in the community started her on Seroquel and she did not know the diagnosis. During an interview on 3/27/2024 at 1:04 p.m., the MDS Coordinator said she was a new MDS nurse. The MDS Nurse said the diagnosis on the Seroquel use was for dementia. The MDS Nurse said the diagnosis was coded incorrectly and was identified on 4/3/2024 after the MDS was completed. She said it should have been corrected when identified and was not done. During an interview on 3/27/2024 at 1:04 p.m., the Regional MDS Nurse was reviewing Resident #56's the chart and identified that the MDS nurse removed the diagnosis of vascular dementia on the chart but failed to correct it on the MDS. During an interview on 3/27/2024 at 1:19 p.m., LVN L said Resident #56 was on Seroquel for vascular dementia with moderate anxiety. LVN L said there was no documentation supporting the order. LVN L said an order for Seroquel was written on 2/23/2024 by another nurse. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident #56's progress note dated 3/27/2024 at 5:02 p.m., the Regional MDS Nurse indicated she spoke with the resident and RP regarding questions about Resident #56's out-patient psychiatric clinic care. The RP revealed Resident #56 had been receiving psychiatric services on an out-patient basis and was in a psychiatric hospital prior to her admission to facility. The Regional MDS Coordinator was able to speak with a provider and verified Resident #56 had a diagnosis of Schizophrenia. The Regional MDS Coordinator indicated the facility would be completing a 1012 form to correct previous PASRR status and Resident #56 may qualify for PASRR services. During an interview on 3/28/2024 at 10:40 a.m., ADON F said vascular dementia was not an appropriate diagnosis for the use of Seroquel. He said the MDS or admitting nurse was responsible for completing the assessment and the MDS nurse completed the assessment based on the community records and history and physical. During an interview on 3/27/2024 at 10:55 a.m., the DON said it was the MDS Coordinator who was responsible for completing the MDS. The DON said she expected the charge nurse and nurses to verify proper diagnosis for psychotropic medications. During an interview on 3/28/2024 at 10:57 a.m., the [NAME] President of Operations said the charge nurse and MDS Coordinator completed the admission assessment, and the diagnosis should be verified. Record Review of the facility's policy titled Electronic Transmission of the MDS dated [DATE] revealed MDS assessments (admission, annual, significant change, quarterly review, etc) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted .Staff members responsible for completion of the MDS receive training on the assessment, data entry and transmission processes .The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data . Record review of the Resident Assessment Instrument indicated A significant error is a comprehensive assessment for an existing resident that must be completed when the Interdisciplinary team determines that a resident's prior comprehensive assessment contains significant error . Nursing homes should document the initial identification of a significant error in an assessment in the clinical record .A significant correction to prior comprehensive assessment is appropriate when .the erroneous comprehensive assessment has been completed and transmitted and submitted into the MDS system .		

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable for 1 of 12 resident (Resident # 17) reviewed for activities of daily living. The facility failed to ensure Resident #17 was provided care and services in her primary language, which was Spanish. This failure could place residents at risk for a decline and diminished quality of life. Findings include: Record review of Resident #17's face sheet, printed 03/25/24, indicated Resident #17 was [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included wedge compression fracture of first lumbar vertebra (this fracture usually occurs in the front of the vertebra, collapsing the bone in the front of the spine and leaving the back of the same bone unchanged, which results in the vertebra taking on a wedge shape), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (the person does not recognize everyday social cues, both verbal and non-verbal), vascular dementia (is caused by a range of conditions that disrupt blood flow to the brain and affect memory, thinking, and behavior), mild, with agitation, and generalized anxiety disorder (excessive, ongoing anxiety and worry can interfere with your daily activities). Resident #17's preferred language was Spanish; Castilian and religion was Catholic. Record review of Resident #17's admission MDS assessment, dated 02/06/24, indicated Resident #17's preferred language was Spanish and needed or wanted an interpreter to communicate with a doctor or health care staff. Resident #17 was understood and understood others. Resident #17 had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #17 had a Mood score of 15 (moderately severe depression) out of 27 related to being bothered by certain problems and the frequency of the being bothered. Resident #17 activity preference was somewhat important regarding keeping up with news and participating in religious services or practices. Resident #17 was dependent for putting on footwear, lower body dressing, and toilet hygiene, maximal assistance for shower/bathe self, moderate assistance for oral hygiene and upper body dressing, and supervision for personal hygiene. Resident #17 was dependent for toilet transfer, chair/bed-to-chair transfer, and sit to stand. Record review of Resident #17's care plan, dated 01/31/24, edited 02/16/24, indicated Resident #17 did not speak in the dominant language of the facility. Language Spanish. Interventions included if a family member or friend is present that speaks/understands language, get permission to call them when needed, provide education for safety awareness, provide visual cueing with communication board, interpreter to enhance communication, and redirect resident as needed and reiterate safety awareness using communication board and interpreter. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
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F 0676 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #17's care plan, dated 01/31/24, edited on 03/19/24, indicated ADLs Functional Status/Rehabilitation Potential: About Me, My name is [Resident #17], I speak only Spanish and I can understand some English. I [Resident #17] do use a communication board to communicate with the staff. But I'm confused due to Dementia and at times and have trouble using the communication board, so I will use an I-Pad for google translate. I do have impaired vision and wear prescription glasses. Sometimes I will crawl out of my bed and sit on the floor to pray. I do require assist with ADLs due to the Dementia and require two people to help me transfer. Interventions included I need assist at times getting up out of the floor when I'm praying or sitting. Record review of Resident #17's care plan, dated 03/01/24, edited on 03/06/24, indicated Behavioral Symptoms: Resident #17 became very combative in the ER and the van, refusing to put seatbelt on, hitting and kicking, grabbing him [Van driver] by the belt. Yelling at ER staff and the van driver. Possible contribution could be the language barrier. Intervention included provided resident with iPad google translator. Record review of Resident #17's progress notes, printed 03/25/24, indicated: On 02/05/24 at 11:44 p.m. by LVN CC, .Resident [#17] sitting up in bed this shift .language barrier continues to inhibit communication this shift .Resident [#17] able to verbalize some needs On 02/09/24 at 10:37 p.m. by LVN CC, .Resident [#17] lying in bed this shift .language barrier continues to disrupt communication between resident and staff On 02/10/24 at 10:21 p.m. by LVN CC, .Resident [#17] lying in bed this shift .language barrier continues to disrupt communication between resident and staff On 02/17/24 at 9:40 p.m. by LVN U, .Resident [#17] is usually very anxious in the evenings .this evening, resident was at the nurses station asking about getting on the bus .communication deficit due to resident [Resident #17] knowing only little English .Unable to understand exactly what resident [Resident #17] is asking .all attempts to calm and redirect unsuccessful until resident's anti-anxiety meds start to work. On 02/19/24 at 1:28 a.m. by LVN U, .all attempts to collect UA have been unsuccessful thus far .resident [Resident #17] refusing in and out cath due to language barrier On 02/19/24 at 10:41 p.m. by LVN CC, .Resident [#17] continues to engage in attention seeking behaviors . continues to self-transfer down onto floor for attention .communication continues to be strained this shift due to resident speaks fluent Spanish only On 02/20/24 at 10:43 p.m. by LVN CC, .Resident [#17] continues to engage in attention seeking behaviors . continues to self-transfer down onto floor for attention .communication continues to be strained this shift due to resident speaks fluent Spanish only On 02/21/24 at 9:50 p.m. by LVN U, .Resident [#17] has been more confused, anxious, and agitated thus far this shift .call placed to resident's daughter so that she could speak Spanish .Resident [#17] is starting to settle down at this time (continued on next page)		

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F 0676 Level of Harm - Actual harm Residents Affected - Few	On 03/02/24 at 1:38 p.m. by LVN J, .patient [Resident #17] found lying on stomach on floor next to bed .very difficult to communicate with patient due to her speaking only Spanish On 03/18/24 at 7:41 a.m. by LVN E, .resident [#17] noted with bruising/ swelling to left knee and x2 abrasion . resident unable to tell staff what happened related to language barrier During an observation on 03/25/24 at 10:52 a.m., Resident #17 was sitting in the 400-hall common area at a table alone. During an observation on 03/26/24 at 8:57 a.m., Resident #17 was sitting in the 400-hall common area at a table alone. In Resident #17's room was an iPad tablet on the nightstand and no other forms of communication tools noted in the room. During an interview on 03/26/24 at 8:58 a.m., LVN E said they communicated with Resident #17 with google translator on their phone or the iPad tablet and tried to understand what she tried to say. During an interview and observation on 03/26/24 at 9:00 a.m., the facility's iPad was used to interview Resident #17 When Resident #17 was asked questions that required more than a yes or no response, she could not be understood. The google translator app did not have the capability for Resident #17 to speak Spanish into the microphone and translate to English Resident #17 could not be interviewed without an interpreter. During an observation on 03/27/24 at 11:34 a.m., Resident #17's room had a sign posted that read Call Before You Fall on the wall in English. Attempted an interview on 03/27/24 at 5:01 p.m. and 5:03 p.m., with LVN U by phone, were unsuccessful. Calls were cancelled and messages were left. There was no returned call before or after exit. During an interview on 03/27/24 at 9:59 p.m., Resident #17's family member said this was Resident #17's second time at the facility. She said Resident #17 was currently admitted at a local hospital because she felt like something was not right. She said about a week after Resident #17 was admitted to the facility, the facility provided her with an iPad with google translator. She said she saw some staff using it but there was the problem with staff understanding what Resident #17 said back to them. She said she did not feel like the facility cared to use the communication tools or get to know Resident #17. She said this admission was the worst experience with staff trying to understand Resident #17. She said she never saw the staff use the communication board with Resident #17. She said yesterday (03/26/24) she saw the communication board on Resident #17's closet floor. She said the facility needed a translator machine for the residents whose primarily language was not English. She said there was one staff member in therapy who spoke Spanish, but she had not seen him in a while. She said she expected the same care for her family member even if Resident #17 was a different race. During an interview on 03/28/24 at 8:40 a.m., LVN E said she used the Google translator or whoever spoke Spanish in the building to help her understand Resident #17. She said she did not know about a communication board to use to with Resident #17. She said Resident #17 was offered snacks and crossword puzzles, but they were not in Spanish. (continued on next page)		

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F 0676 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/28/24 at 9:00 a.m., the Regional Nurse said she was making Resident #17 a communication book/binder with basic communication phrases and faces. She said she was also printing out crossword puzzles in Spanish and spiritual based coloring pages. She said she was not aware Resident #17's Call Before You Fall sign posted was in English. She said she would take care of that also. During an interview on 03/28/24 at 9:13 a.m., CNA K said most staff spoke to Resident #17 in English. He said Resident #17 replied appropriately to yes and no questions. He said anything else besides yes or no answers, staff had to decipher what she tried to say. He said he had not seen staff use the iPad or communication board to talk to Resident #17. He said it was important to have communication tools to help understand Resident #17's want and needs. He said he never saw Resident #17 watch television or do activities. He said it would be important for the activities to be in Resident #17's preferred language. He said there used to be another resident who spoke Spanish, Resident #17 hung out with, but she was discharged recently. He said Resident #17 normally sat at the table alone with her cell phone. During an interview on 03/28/24 at 9:15 a.m., the Interim DON said staff should be using goggle translator, staff who spoke Spanish, or contacted Resident #17's family members to translate. She said at nighttime when there was less staff available to translate, Resident #17's family did visit at night a lot. She said Resident #17 should have a communication board and staff using it. She said she did not expect the communication board to be in the floor in the closet partially under clothes. She said Resident #17's fall sign should be in Spanish. Attempted interview on 03/29/24 at 9:31 a.m., with LVN CC by phone was unsuccessful. A message was left. During an observation on 03/29/24 at 9:34 a.m., revealed in Resident #17's room was a posted activity calendar and Call Before You Fall sign on the wall in English. In Resident #17's closet floor, partially concealed by a bag of briefs and clothes, was an 8x10 laminate sheet with pictures and words in English was noted (communication board). During an interview on 03/29/24 at 1:23 p.m., the AD said she had been at the facility for [AGE] years. She said Resident #17 went to activities sometimes but did not stay for long. She said she did bring activities to Resident #17, but they were not in Spanish. She said she mostly brought Resident #17 pictures to color. She said she asked a Deacon from a local Catholic church to come visit with Resident #17. She said she communicated with the Deacon last on 03/06/24, but no one visited with Resident #17 yet. She said Resident #17 also had dementia but had not tried activities like sorting socks with her. She said activities should be in Resident #17's preferred language so she did not feel left out and frustrated. During an interview on 03/29/24 at 11:01 a.m., CNA A said she worked with Resident #17 often. She said it was hard to communicate with Resident #17 because of the language barrier and mumbling. She said she never saw staff use the iPad or communication board to communicate with Resident #17. She said the facility use to have another resident who sat with Resident #17, and they did activities together, but she discharged . She said since the other residents left, Resident #17 had not cared to do activities. (continued on next page)		

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F 0676 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/29/24 at 11:45 a.m., LVN J said communicating with Resident #17 was frustrating for her and the resident. She said Resident #17 answered simple questions that only required yes or no responses. She said Resident #17 had to gesture with her hands where she had pain, when asked. She said she tried to use a translator or got staff to help her talk to Resident #17. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected staff to use the communication tools the facility provided for Resident #17 which were the communication board, iPad with Google translator, or Spanish speaking staff members. She said she expected staff to let her know if the communication tools were not working for Resident #17. She said she expected signs and activities to be in the resident's preferred language. She said she had given the AD an in-service on providing activities in the resident's preferred language. She said it was the facility's responsibility to find ways to effectively communicate with Resident #17. She said Resident #17's needs needed to be met. During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said staff should use the communication tools provided to communicate with Resident #17. He said staff should notify management if the communication tools were not working. He said it was the facility's responsibility to improve or maintain a resident's ADLs. Record review of the facility's Translation and/or Interpretation of Facility Services policy, revised 06/2020, indicated .this facility's language access program will ensure that individuals with limited English proficiency shall have meaningful access to information and services provided by the facility .the types of language access services provided by this facility shall be determined by the following factors .the size of the eligible LEP population served by the facility .the frequency .the nature and/or importance of the information or service .the resources available .all LEP person shall receive a written notice in their primary language of their rights to obtain competent oral translation services free of charge .competent oral translation of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner .a staff member who is trained and competent in the skill of interpreting .a staff interpreter who is trained and competent in the skill of interpreting .contracted interpreter service .voluntary community interpreters who are trained and competent in the skill of interpreting .telephone interpretation service . interpreters and translators must be appropriately trained in medical terminology .family members and friends shall not be relied upon to provide interpretation services for the resident unless explicitly requested by the resident .it is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 17 (Resident #52) residents reviewed for quality of care. The facility failed to ensure Resident #52 received daily wound care per her care plan. A complaint was filed by a local hospital that Resident #52 arrived in the ER on [DATE] with dressings dated 02/29/24. This failure could place residents of risk for not receiving appropriate care and treatment, a decreased quality of life, and pressure ulcers. Findings included: Record review of Resident #52's face sheet printed 03/25/24 indicated Resident #52 was a [AGE] year-old, female and admitted on [DATE] and 03/15/24 with diagnoses including congestive heart failure (is a serious condition in which the heart doesn't pump blood as efficiently as it should), cellulitis (is a deep infection of the skin caused by bacteria.), Type 1 diabetes (is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood), rash and skin eruption (is an area of swollen, irritated skin). Record review of Resident #52's admission MDS assessment dated [DATE] indicated Resident #52 was understood and understood others. The MDS indicated Resident #52 had a BIMS of 15 which indicated intact cognition. The MDS indicated Resident #52 required moderate assistance for lower body dressing, shower/bathe self, and toilet hygiene, supervision for upper body dressing and putting on footwear, set up for personal and oral hygiene. The MDS indicated Resident #52 was occasionally incontinent of urine but always of bowel. The MDS indicated Resident #52 did not have any unhealed pressure ulcers/injuries, wounds, or skin problems. The MDS indicated Resident #52 received skin and ulcer/injury treatments of application of nonsurgical dressings, applications of ointments/medications other than to feet, and application of dressings to feet. Record review of Resident #52's care plan dated 02/09/24, edited on 03/15/24 indicated Resident #52 had post-surgical wound to right foot following wound closure attempt on 11/3 status post amputation of fourth and fifth toe. Intervention included right lateral foot (the outer edge of the foot) incision, cleanse with normal saline (is regarded as the most appropriate and preferred cleansing solution), apply calcium alginate (absorb wound fluid while creating a moist environment), then cover with dry dressing every day. Record review of Resident #52's Consolidated Physician Order dated 02/01/24-03/31/24 indicated: *02/08/24-03/15/24 (DC Date): Left foot 3rd toe, cleanse with wound cleanser, pat dry, apply Opticell AG (conformable, gelling fiber dressings) to affected area, cover with Band-Aid. Change daily. DX: Cellulitis, unspecified. Once a day; 6:00 AM-6:00 PM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*02/08/24-open ended: Right lateral foot (the outer edge of the foot) incision, cleanse with wound cleanser, pat dry with gauze, place Opticell AG in open wound, and cover with gauze. Secure with rolled gauze. DX: Cellulitis, unspecified. Once a day; 6:00 AM-6:00 PM. Record review of Resident #52's Treatment Administration Record dated 03/01/24-03/27/24 indicated: *Left foot 3rd toe, cleanse with wound cleanser, pat dry, apply Opticell AG to affected area, cover with Band-Aid. Change daily. DX: Cellulitis, unspecified. Once a day; 6:00 AM-6:00 PM. Administration documented: 03/01/24 (LVN L), 03/03/24 (LVN T). Administration documented, not administered: Other on 03/02/24 (LVN R). No documentation noted on 03/04/24. *Right lateral foot incision, cleanse with wound cleanser, pat dry with gauze, place Opticell AG in open wound, and cover with gauze. Secure with rolled gauze. DX: Cellulitis, unspecified. Once a day; 6:00 AM-6:00 PM. Administration documented: 03/01/24 (LVN L), 03/03/24 (LVN T). Administration documented, not administered: Other on 03/02/24 (LVN R). No documentation noted on 03/04/24. Record review of an Intake Report on Resident #52 dated 03/05/24 at 11:59 a.m., indicated .Patient [Resident #52] came to ER with dressing to both ankles .dressings had not been changed since 02/29/24 . when this nurse called the nursing home to get a history, the nurse stated (LVN L) stated that the order read to be changed daily .patient's dressing stunk and had moderate amount of drainage .patient [Resident #52] is diabetic and has a slower healing rate and is at higher risk for infection . Record review of the facility's resident roster dated 03/25/24 indicated Resident #52 was discharged to the hospital. During an interview on 03/26/24 at 8:44 p.m., the ER nurse said Resident #52 came to the ER about 3 weeks ago (03/04/24) for vaginal and nasal bleeding. She said her nursing notes stated Resident #52 had bilateral ankle dressings. She said she noticed the dressing was dated for 02/29/24 in the ER. She said she called the facility about the dressings change orders and spoke with LVN L. She said LVN L told her Resident #52's dressings were due to be changed daily. She said LVN L said she guess Resident #52's dressings had not gotten changed over the weekend. During an interview and observation at the local hospital, on 03/27/24 at 8:25 a.m., Resident #52 was in the hospital bed drowsy but awake. Resident #52 said she was in the hospital because of her heart. She said she could not remember her visit to the hospital before this admission. She said she had a lot of dressings on legs and feet and did not think the facility changed it every day. During an interview on 03/28/24 at 9:15 a.m., LVN L said when she did dressing changes, she dated and initialed the dressing. She said she did change Resident #52's dressings when she worked except the day, she sent her to the hospital on 03/04/24. She said Resident #52 was sent to the ER before she had the chance to change the dressings. She said she did not remember the date on Resident #52's dressing when she sent her to the hospital on 03/04/24. She said she got a phone call from theER on [DATE]. She said the ER nurse asked her about Resident #52's medications, dressings orders, how often the dressing changes were scheduled to be done, and what here initial were. She said the ER nurse told it was her initials on the dressing. She said the facility had a treatment nurse then she left, and the bedside nurses were doing the dressings changes. She said the facility recently got a treatment nurse in the last 2-3 weeks. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/24 at 9:40 a.m., attempted to interview LVN T by phone. Unable to leave message. During an interview on 03/28/24 at 5:40 p.m., LVN R said she may not had done Resident #52's dressing changes on 03/02/24. She said Resident #52's physician orders and care plan stated Resident #52's dressings changes were to be done daily. She said it was hard to follow the care plan or physician orders to do Resident #52 dressings changes because half the time the facility did not have the right dressings ordered, enough of the ordered wound care supplies, or the supply room was so unorganized, supplies could not be found. She said not doing Resident #52's daily scheduled dressing changes placed resident at risk for infections. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected nursing staff to perform wound care as scheduled. She said if the treatment nurse did not do the dressings changes then the bedside nurse was responsible. She said she expected the nursing staff to notify the DON or ADON about wound care supplies issues. She said she was made aware by the nursing staff when the company took over there were issues with wound care supplies. She said the wound care supplies had been organized and someone was solely responsible for ordering and stocking. She said the facility also had a treatment nurse now responsible for wound care. She said she had just learned today (03/29/24) about Resident #52's dressings change not being done due to wound care supply issues. She said Resident #52's care plan interventions should have been followed for daily wound care. She said not doing scheduled wound care placed resident at risk for infection. During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said care plan intervention should be followed by staff. He said wound care orders should done as ordered. He said if supplies were needed to do the ordered dressing change then he expected staff to notify the DON. Record Review of a facility's Care Plans-Comprehensive Person Centered policy dated 4/19/2021 indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . procedure .receive the services and/or items included in the plan of care .See the care plan and sign it after significant changes are made .incorporate identified problem areas .reflect currently recognized standards of practice for problem areas and conditions . Record review of a facility's Wound Care policy revised 06/2022 indicated .preparation .review the resident's care plan to assess for any special needs of the resident .dress wound .mark tape with initials, time, and date and apply dressing .the following information should be recorded in the resident's medical record .the type of wound care given .the date and time the wound care was given .the name and title of the individual performing the wound care .all assessment data .how the resident tolerated the procedure .the signature and title of the person recording the data .		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review the facility failed to ensure residents environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 4 of 8 residents (Resident #38, Resident #17, Resident #110, and Resident #35) reviewed for accidents and supervision. 1.The facility failed to put interventions in place to keep Resident #38 from all harmful items. *On 02/18/24, LVN E documented Resident #38 was on the floor, face down with the call light cord wrapped around her neck x4. No harmful items were removed after the incident, from Resident #38's room to ensure her safety. *On 03/09/24, CNA S reported Resident #38 was stabbing herself in the abdomen with scissors. CNA S removed the scissors from Resident #38 put no other actions were initiated until later. The facility failed to put interventions in place to keep Resident #38 from harming herself after reported self-harming behaviors. *The facility did not immediately initiate 1:1 monitoring after self-harming incident on 03/09/24. The facility classified Resident #38's incident on 02/18/24 as a fall and shortened her call light and placed a fall mat bedside her bed. *The facility did not ensure Resident #38 was seen after a counseling evaluation and treatment ordered was placed on 02/15/24 and a psych evaluation referral was signed by Resident #38 on 03/04/24. The facility failed to follow their Suicide Threat policy after incidents on 02/18/24 and 03/09/24. Resident #38 was left alone after self-harmful behaviors was witnessed and reported. The facility failed to in-service staff of Suicide Prevention after Resident #38's reported self-harming behavior on 03/09/24. LVN R was the only staff member documented on in-service roster. 2. The facility failed to transfer Resident #17 in safe manner by her care planned needs. Resident #17 was transferred by CNA A without a gait belt which resulted in fall causing back pain requiring x-rays. 3. CNA A transferred Resident #110 without a gait belt resulting in laceration to the back of his head. 4. CNA B transferred Resident #35 with a Hoyer lift by herself resulting in a bruise to her left forearm. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on 03/28/24 at 3:45 p.m. While the IJ was removed on 3/29/24 at 12:41 p.m. p.m., the facility remained out of compliance at a scope of a pattern with a potential for with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk to physical harm and could lead to additional pain and suffering. Findings include: Record review of Resident #38's face sheet printed 03/25/24 indicated Resident #38 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including transient cerebral ischemic attack (is a temporary blockage of blood flow to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) affecting left non-dominant side, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #38's quarterly MDS assessment dated [DATE] indicated Resident #38 was understood and understood others. The MDS indicated Resident #38 had adequate hearing, clear speech, and adequate vision. The MDS indicated Resident #38 had a BIMS score of 13 which indicated intact cognition. The MDS indicated Resident #38 did not have behaviors such as psychosis or physical or verbal behavioral symptoms. The MDS indicated Resident #38 rated going outside to get fresh air when the weather was good as not very important. The MDS indicated Resident #38 upper extremity limitation in range of motion on one side of the body. The MDS indicated Resident #38 admission performance requirement was maximal assistance for putting on footwear, lower body dressing, and toilet hygiene and moderate assistance for oral hygiene, shower/bathe self, upper body dressing, and personal hygiene. The MDS indicated Resident #38 received antianxiety and antidepressant medication during the last 7 days of the assessment period. Record review of Resident #38's care plan dated 03/09/24, edited on 03/11/24 indicated CNA stated that Resident #38 expressed thoughts of harming self: Resident #38 was in her room with a pair of scissors, and it appears that she was trying to stab herself. Resident #38 stated that she had never thought of anything like that. And she was upset that the CNA even thought that. Interventions created on 03/11/24 included: *Nurse assessed residents' abdomen, and there are no signs of resident trying to stab herself such as redness, discoloration, and marks. *Telemed visit conducted with NP GG- Local Counseling Provider and recommendation made to discontinue 1:1 supervision and suicide precaution on 03/11/24. *Notify MD/RP of suicidal ideations. *Nurse to assess mood and behaviors every shift and document findings. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Provide 1:1 supervision to resident, document every 15 minutes checks during 1:1, Resident to remain on 1:1 until psych provider clears suicidal ideations, discontinued 3/11/24 post psych consult with Local Counseling Provider *Remove all sharp items from room, call light cord, curtains, blinds, phone charger, etc. Provide bell/alternate call light system to resident. Hang sheet over window for privacy. *Resident engages in audiobooks and enjoys listening to Bible app. She enjoys playing on her cell phone and enjoys television. Denies need for activity supplies in room. States she has plenty to do. *Resident #38 was interviewed by the nurse and Resident stated that she would never harm herself that she does not know why the CNA would even say anything like that. Resident #38 was Ax3-4 with a BIMS 15. *Social services to assess mood and behavior and document findings. Record Review of Resident #38's care plan dated 02/14/24, edited on 03/18/24 indicated Resident #38 was at risk for falls due to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Falls: 02/17/24: Resident #38 had an unwitnessed fall from her bed with no injury. Intervention edited on 03/18/24 included therapy screen, maintenance to shorten call light string, staff to ensure call light is untangled and within reach. Monitor for delayed injuries, may have fall mat at beside while in bed. Record review of Resident #38's progress notes by LVN L dated 02/15/24 at 1:45 p.m., indicated .received psych orders to eval and treat from NP HH . Record review of Resident #38's progress notes by LVN E dated 02/18/24 at 6:29 a.m., indicated .sn [LVN E] noted resident in floor face down in right side of bed with call light wrapped around neck 4 times .sn [LVN E] asked resident what happened resident stated she trying to get call light undone and kept wrapping it around and somehow fell .no injuries noted .no abnormalities/deformities noted .sn [LVN E] and cna assisted resident back to bed via Hoyer lift .prn pain pill administered po .residents son notified .don notified .NP notified by fax .neuros initiated .edited by: LVN E on 02/19/24 10:04 AM Reason: Incorrect data . Record review of Resident #38's progress notes by LVN E dated 02/18/24 at 6:29 a.m., indicated .sn [LVN E] noted resident in floor face down in right side of bed tangled in call light .sn [LVN E] asked resident what happened resident stated she trying to get call light undone and kept wrapping it around and somehow fell .no injuries noted .no abnormalities/deformities noted .sn [LVN E] and cna assisted resident back to bed via Hoyer lift .prn pain pill administered po .residents son notified .don notified .NP notified by fax .neuros initiated . Record review of Resident #38's progress notes by SW dated 03/04/24 at 12:07 p.m., .Resident #38 stated she is having a hard time with her new discharge plan of long-term care but has not desire to leave the facility .SW discussed a referral to local counseling provider .Resident #38 agreed to the referral . (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #38's progress notes by DOCR dated 03/09/24 at 9:20 a.m., indicated .this nurse was told by CNA [CNA S] that she caught this resident with a pair of scissors, and that she wanted to commit suicide .this nurse went right away to ask the resident about the scissors .resident stated I [Resident #38] found them in the drawer, and the aide walked in and said you will not commit suicide in this room! .And I [Resident #38] told her why would I ever do something like that, I wouldn't even think about killing myself .I [Resident #38] found these in the drawer and I don't know where they came from .they could have been here before they moved me in this room .the aide took them but I don't what she did with them . Record review of Resident #38's progress notes by Interim DON dated 03/09/24 at 3:20 p.m., indicated . during rounds visited with resident, resident pleasant and no complaints .mentioned she had an issue this morning .she reported that CNA [CNA S] took her scissors and she didn't know why .CNA [CNA S] told resident [Resident #38] that she had a recent suicide in her family and that is why her awareness is heightened .resident reported that she is going to go to the long term care side of the building soon and its going to be an adjustment for her . Record review of Resident #38's progress notes by LVN R dated 03/09/24 at 11:38 a.m., indicated .8:30 am . CNA [CNA S] reported to this nurse [LVN R] that found Resident [Resident #38] in her room with a pair of scissors and it appeared that she was trying to stab herself .CNA [CNA S] stated that she grabbed the scissors from the Resident and asked what are you doing? .and Resident [#38] stated I [Resident #38] was trying to kill myself .CNA [CNA S] gave the pair of scissors to this nurse [LVN R] .the nurse went into Residents [#38] room to interview her to get her side of the story .resident [#38] stated she did not try to stab herself, and that she would never try to kill herself and that she does not have the guts to do that .DOCR went in to get a statement from resident and resident told her the same thing, that she would not ever try to kill herself . Record review of Resident #38's progress notes by LVN R dated 03/10/24 at 9:12 a.m., indicated .no suicidal remarks or attempts made or reported this shift .Resident [Resident #38] appears to be in pleasant mood this shift . Record review of Resident #38's progress notes by LVN JJ dated 03/10/24 at 10:30 p.m., indicated .resident [Resident #38] placed on 1:1 per Interim DON due to self-harm behaviors on 03/10/24 .sitter has been present to ensure resident safety .at this time patient denies any current thoughts or urges to self-harm . Record review of CNA S written statement dated 03/09/24 at 7:56 a.m., indicated .I went in room [ROOM NUMBER] to pick up her [Resident #38] breakfast tray and the resident was stabbing at her stomach with some scissors .I called her name and she threw them in the drawer and put her foot up to it so I couldn't get them, I told her I had to take them because we can't have them up here .she [Resident #38] stated well if it was a knife I could have cut my throat .I said I have to let the nurse know you're talking like this . she stated well if you tell on me I'm going to say you are mean to me .I told her I can't let her hurt herself and I got the scissors out the drawer .took them to the nurse and let her know what happened . (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an undated and untimed statement by the Interim DON (provided after entry on 03/27/24) indicated, .On 03/09/24 during rounds visited with resident [Resident #38], resident pleasant and no complaints .mentioned she had an issue this morning .she reported CNA [CNA S] took scissors and she [Resident #38] did not know why . on Sunday 03/10/24 afternoon, I [Interim DON] read in Matrix nurse notes that agency nurse [LVN R] documented that resident attempted suicide with scissors . Record review of Resident #38's local counseling service provider prepared by SW, dated 03/04/24 indicated .reason for referral: depressive symptoms and anxiety .referral/treatment consent form and doctor's order need to be completed PRIOR TO provision of services and COPY OF EACH FAXED to .Corporate Office . along with a current face sheet .please assure there is an order reads similar to: Please refer to .Evaluation and Treatment . During an interview and observation on 03/25/24 at 10:55 a.m. Resident #38's room was dark and quiet. Resident #38 said she had no complaints about the facility, and nothing had happened in her bathroom recently. No fall mat at bedside. During an interview and observation on 03/26/24 at 11:04 a.m., Resident #38's room was dark and quiet. Fall mat noted on left side of the bed. Resident #38 said the facility added it yesterday because she had a little incident and fell out of the bed. She said the fall mat was something soft in case she fell out of the bed again. She said it had been a bad morning that day. She said CNA S had found her in the wheelchair headed out the room not properly dressed. She said she did not attempt suicide with scissors. She said she was reaching for her hairbrush in the nightstand drawer and picked up the scissors instead. She said CNA S asked why she had the scissors and she told her she found them in the drawer. She said she did suffer depression and anxiety but was on medication for it. She said she really missed her dog. She said her dog was a certified support dog and wanted to have at the facility full time. During an interview on 03/26/24 at 4:45 p.m., CNA S said she was picking up lunch trays and looked in Resident #38's room and saw her stabbing at her stomach with scissors. She said she asked her what she was doing, and she threw the scissors in the drawer. She said Resident #38 said If it was a knife, I would have been able to cut my throat with it! She said Resident #38 put her foot up against the drawer so she could not get the scissors. She said she told Resident #38 she had to get the scissors and had to let the nurse know what was going on. She said Resident #38 said If you tell on me, I will say you hurt me! She said Resident #38's foot slipped from the drawer enough for her to get the scissors. She said she took the scissors to LVN R. She said LVN R said she would take care of it. She said she went to finish picking up trays and heard Resident #38 with probably her son telling him I rammed her knee in the bathroom. She said she went back to the nurse's station to ask LVN R to go to Resident 338's room and talk to her. She said LVN R said she would. She said she took the trays to the dining room and wrote her statement about the incident. She said she saw the DOCR and told her about Resident #38 having the scissors. She said the DOCR asked her if someone was sitting 1:1 with Resident #38 and I told her, No. She said the DOCR went to LVN R and asked her why Resident #38 was alone. She said LVN R told the DOCR, she had spoken with Resident #38 and denied trying to stab herself with scissors. She said Resident #38 was probably left alone for 20-30 minutes because she gave a bath and got linen before she saw the DOCR and told her about the scissors. She said Resident #38 had made other comments about hurting herself before. She said on 03/09/24, Resident #38 did not have 1:1 supervision but staff members were going in and checking on her. She said Resident #38 probably should not have been left alone in case she really tried to harm herself. She said she told LVN R so she felt like she should have start everything like 1:1 monitoring immediately. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/27/24 at 10:04 a.m., a family member of Resident #38 said he had been informed of his family members voiced suicide attempts. He said when Resident #38 got out the back door on 03/03/24 without permission, she later texted him saying she wanted to walk into traffic. He said he thought he told the case worker Resident #38 made that statement. He said Resident #38 did not have a history of suicidal ideations. He said his family member wanted to come home, but he could not care for her anymore. During an interview on 03/27/24 at 11:27 a.m., the DOCR said CNA S saw her in the hallway and told her after breakfast, Resident #38 had scissors and would be mad she reported to her what happened. She said she went into Resident #38's room and she denied allegation of harming herself and having scissors. She said LVN R was at the nurse's station when she got on the hall to talk to Resident #38. She said when she headed towards Resident #38's room, LVN R followed her. She said Resident #38 was alone when she went into her room to talk to her. She said after she finished talking to Resident #38 about the incident with CNA S, she left for the day, called the Interim DON and she showed. She said she did not know the exact time the Interim DON arrived at the facility. She said the Interim DON lived about 3 hours away from the facility. During an interview on 03/27/24 at 11:39 a.m., the SW said Resident #38 was anxious and depressed when she first admitted to the facility. She said she was initial supposed to go back home but changed plan and she was staying for long term care. She said Resident #38 had some adjustment issues but was on medication and psych services. She said Resident #38's family member never reported to her about her texting him she wanted to walk into traffic. She said Resident #38's family had reported attention seeking behaviors like constantly calling and how she had ruined relationships with her behavior. She said Resident #38 family member said Resident #38 would not harm herself, it was just attention seeking and she would not do it. She said she was not notified of the incident on 03/09/24 until Monday, 03/11/24, when she returned for work. She said she assessed Resident #38 on 03/11/24 and she did not make any comments of self-harm. During an interview on 03/27/24 at 12:00 p.m., the Interim DON said she did not know where the 1:1 monitoring documentation paperwork was. During an interview on 03/27/24 at 12:59 p.m., LVN R said she was agency staff but had worked with Resident #38 often. She said Resident #38 had never told her she was depressed. LVN R said she went to speak to Resident #38 after CNA S brought her the scissors and told her Resident #38 tried to harm herself with them. She said CNA S told her she took the scissors from Resident #38 and asked her what she was doing. She said the first time, CNA S said Resident #38 said I don't know or I'm not doing anything. She said she went to speak with Resident #38, and she said CNA S was mad at her because she did not want to assist her to the restroom. She said Resident #38 said she would never harm herself or have the guts to do it. She said she assessed Resident #38's stomach and there were no marks or anything. She said Resident #38 tried to call her family member. She said she tried to call Resident #38's family member also. She said later, her and DOCR went to talk to Resident #38. She said Resident #38 said CNA S may have been frustrated when she took her to the bathroom and did not ram her knees on purpose. She said the Interim DOB showed up and spoke with Resident #38. She said the Interim DON told CNA S to apologize to Resident #38. She said Resident #38 was left alone after the incident, but she was checked on frequently. She said she worked until 6pm on 03/09/24. She said 1:1 monitoring for Resident #38 was started on 03/10/24. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/27/24 at 1:34 p.m., the Interim DON said she went to Resident #38's room on 03/09/24 and she said CNA S took her scissors and accidentally bumped her knee. She said she did speak with LVN R, but LVN R never mentioned to her Resident #38's self-harming incident. She said the DOCR did not call her on 03/09/24. During an interview on 03/28/24 at 8:40 a.m., LVN E said on 02/18/24, Resident #38 fell out of her bed. She said Resident #38 said she was trying to get the call light cord and rolled out of the bed. She said Resident #38 did have the cord wrapped around her neck four times when she found her. She said there were no marks on Resident #38 neck after the fall. She said she did not modify her nursing note to state tangled instead of wrapped around neck. She said she believed what Resident #38 said because she was confused, and her room was dark when she arrived. She said she did not think Resident #38 was trying to harm herself. She said she did not know what interventions were put in place after that incident on 02/18/24 because she was agency staff then. She said it was ruled a fall so nothing was taken from her room or 1:1 monitoring done. During an observation on 03/28/24 at 9:00 a.m., Resident #38 was lying down in a dark room asleep. During an interview on 03/28/24 at 4:30 p.m., the SW said the psych treat and evaluation order placed on 02/15/24 was done without a discussion between the morning meeting. She said normally referrals were discussed between her and NP HH. She said then the referral was sent by fax or email to the local counseling provider. She said she preferred doing it by email. She said on 03/04/24, she did a well check and got consent for an evaluation. She said the local counseling provider normally took less than 3 weeks to see residents for services. She said telehealth could be used if needed for some residents. She said medication management was normally done by NP GG. And a Psychologist normally did the evaluations. She said the facility had a licensed counselor that served the facility. She said she did not believe the delay in psych service contributed to Resident #38's self-harming incidents. She said Resident #38 just wants to go home. On 03/29/24 at 9:46 a.m., attempted to contact NP HH by phone and text message. No response before or after exit. During an interview on 03/29/24 at 12:19 p.m., the interim DON said she was not aware of Resident #38's incident on 02/18/24. She said it looked like they tried to cover it up. She said she was also not aware of Resident #38 telling her son she wanted to walk into traffic. She said the Suicide policies should have been followed for Resident #38's incidents. She said the Suicide policies were not new and staff had been re in serviced. She said harmful items should have been removed from Resident #38's room until she was assessed. She said she expected nurses to document every 4 hours and CNAs every 15 mins when the resident is being monitored. She said Resident #38 was able to be seen on Telemed by NP GG who determined she could come off 1:1 monitoring. She said the psych referral process had always been the same and the SW was terminated for not completing them social service duties. She said it was important to take all reports of threats seriously and addressed right way to prevent something from happening. During an interview on 03/29/24 at 12:21 p.m., the Interim ADM said all suicide threats should be taken seriously. He said he expected staff to address the suicide threat or attempt immediately and follow the facility's policies. He said harmful items should be removed from the resident's room and monitoring done. He said it was to keep the resident safe. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an undated facility's in-service Suicide Prevention Program revealed LVN R signature. Record review of a facility's Suicide Threats policy revised 12/07 indicated .resident suicide threats shall be taken seriously and addressed appropriately .staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse .the nurse supervisor/charge nurse shall immediately assess the situation and shall notify the Charge nurse/Supervisor and/or Director of Nursing Services of such threats .all staff member shall remain with the resident until the nurse supervisor/charge nurse arrives to evaluate the resident . Record review of a facility's Mandatory Notifications policy revised 02/25/23 indicated .employees must immediately notify the facility Administrator and DON if any of the following events occur .resident with suicidal ideations, suicide attempts . Record review of an undated facility's Suicidal Precaution Management policy indicated .if a resident, who is voicing suicidal thoughts or attempts suicide, is a danger to self or others .physician, psychiatrist/counselor/psychologist, and family are notified immediately .referral is made at this time .suicide precautions are implemented immediately if resident is deemed to be threat to themselves or others .suicide precautions will be implemented immediately for any resident that presents with a significant level of depression or suicidal preoccupation and will be used to address the risk factors .suicide precautions include .one on one supervision .call light removed .if available, a wander device is placed on the patient's wrist or ankle .a licensed nurse will assess the resident at least every four hours and document the assessment . record that the resident as checked every fifteen minutes . Record review of an undated facility's Processing Psych Referrals policy indicated .nurse receives order for psych referral and enters matrix order .nursing to notify social services of needed referral and discuss in daily C.A.R.E meeting to ensure need for referral is communicated .social services will complete referral form/consents as required for psych referral and submit to psych provider in a timely manner .social services to follow up on resident until psych provider visit is made . 2. Record review of Resident #17's face sheet printed 03/25/24 indicated Resident #17 was [AGE] year-old, female and admitted on [DATE] with diagnosis including wedge compression fracture of first lumbar vertebra (this fracture usually occurs in the front of the vertebra, collapsing the bone in the front of the spine and leaving the back of the same bone unchanged, which results in the vertebra taking on a wedge shape). Record review of Resident #17's admission MDS assessment dated [DATE] indicated Resident #17 was understood and understood others. The MDS indicated Resident #17 had a BIMS score of 12 indicated moderate cognitive impairment. The MDS indicated Resident #17 was dependent for putting on footwear, lower body dressing, and toilet hygiene, maximal assistance for shower/bathe self, moderate assistance for oral hygiene and upper body dressing, and supervision for personal hygiene. The MDS indicated Resident #17 was dependent for toilet transfer, chair/bed-to-chair transfer, and sit to stand. Record review of Resident #17's care plan dated 01/31/24, edited on 03/19/24 indicated ADLs Functional Status/Rehabilitation Potential: About Me, My name is [Resident #17], I speak only Spanish and I can understand some English. I require two people to help me transfer. Intervention included Resident #17 needed assist with all transfers related to my diagnosis. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #17's care plan dated 07/28/23, edited on 03/18/24 indicated Falls: 03/11/24: Resident #17 had a fall during transfer. Intervention included in-service CNA [CNA A] to always use a gait belt during transfer and lock the wheelchair prior to transferring the resident. Record review of Resident #17's progress notes by LVN J on 03/11/24 at 8:36 a.m., indicated .patient [Resident #17] fell during transfer from bed to chair with assistance of one when wheelchair moved and patient fell .CNA [CNA A] called this SN to assess patient .on SN arrival patient lying on back on the floor trying to get up .this SN assessed patient, no injury noted .patient motioned that she had hit the back of her head, no bumps or bruising noted .patient also c/o moderate pain to lumbar region .no increased pain on palpation .spoke with admin .and instructed me to have x-rays done here .call to x-ray and paperwork sent for thoracic and lumbar x-ray to be done . Record review of Resident #17's progress notes by LVN J on 03/11/24 at 10:45 a.m., indicated .left shoulder x-ray ordered as well due to pian since fall . Record review of Resident #17's progress notes by LVN J on 03/11/24 at 3:42 p.m., indicated .all x-rays WNL, doctor notified as well as NP . Record review of Resident #17's Safety Event-Fall by LVN J, dated 03/11/24 indicated .fall location was in the resident room .transferring with assistance of 1 .witnessed fall .lumbar back pain .no injury noted .x-rays ordered to rule out back injury . During an interview on 03/29/24 at 11:01 a.m., CNA A said she started at the facility in mid-January 2024. She said CNAs did not receive gait belts until 3 weeks ago. She said the last week the ADON went to PT to figure out if Resident #17 was a 1- or 2-person transfer. She said the charge nurses were never on the same page about the amount of assistance Resident #17 required for transfer. She said the week before last was the first time a gait belt was used on Resident #17. She said when she originally hired on it was somewhere else. She said she was transferred to the floor with 1 week of shadowing another CNA. She said she felt like there was no training on how to properly do things. She said she did not know what resident needed what type of assistance for cares. She said the facility did provide in-services and trainings on transfers and things, but it was verbal and never demonstrated. She said it was important to use a gait belt to transfer for the safety of the resident. She said the resident could fall if transfers were done without gait or right amount of assistance. During an interview on 03/29/24 at 11:45 a.m., LVN J said she assessed Resident #17 after the fall on 03/11/24. She said CNA S transferred Resident #17 alone and with no gait belt. She said after the fall Resident #17 complained of pain and x-ray was done which was all fine. She said Resident #17 was a 2 person transfer assist. She said gait belts were needed to stabilize the resident and a secured hold in case she started to fall. During an interview on 03/29/24 at 12:19 p.m., the Interim DON said she expected staff to use gait belts for one and two person transfers. She said she expected the right amount of assistance to be provided to the resident according to their care plan. She said the gait belt was used for the safety of the resident. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of the undated face sheet revealed Resident #110 was a [AGE] year-old male, admitted on [DATE] and discharged [DATE]. Resident #110 had diagnoses that included: wedge compression fracture of the fourth lumbar vertebra with routine healing (the spine weakens and crumbles, loss of bone mass), depression (loss of interest in activities causing significant impairment in daily life), atrial fibrillation (irregular impulses in the heart), and congestive heart failure (accumulation of fluids in the body). Record review of the admission MDS dated [DATE] revealed Resident #110 had a BIMS score of 11 indicating moderate cognitive impairment. The MDS indicated he had no impairment for his upper or lower extremities and used a walker or wheelchair. Chair/bed to chair and toilet transfer indicated he required partial to moderate assistance. Resident #110 had a fall with fracture prior to admission per the MDS. Record review of the care plan dated 3/6/24 revealed Resident #110 had daily weights related to CHF, was in the facility for therapy for a wedge compressi [TRUNCATED]		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview, and record review, the facility failed to ensure residents who had urinary incontinence, received appropriate treatment and services to prevent urinary tract infections to the extent possible for 1 of 8 residents reviewed for urinary incontinence. (Resident #22) 1. The facility failed to provide routine incontinent care for Resident #22, resulting in a urinary tract infection. This failure could place residents at risk for urinary tract infections, pain, confusion, and sepsis (infections that spread to the blood). Findings included: Record review of an undated face sheet revealed Resident #22 was a [AGE] year-old, admitted on [DATE] with the diagnoses of Alzheimer's disease (progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), depression, and anemia (a condition in which the body does not produce enough red blood cells). Record review of an admission MDS assessment dated [DATE] revealed Resident #22 had a BIMS of 07 which indicated a moderate memory impairment. Resident #22 required extensive assistance with bed mobility and extensive assistance with transfer and toileting. The MDS indicated Resident #22 was incontinent of bowel and bladder. During an observation and interview on 03/25/2024 at 9:45 a.m., Resident #22 was noted to be lying in bed and a strong smell of ammonia (indication of concentrated urine) was noted. Resident #22 stated she had not been changed since before day shift came on at 6 a.m. Resident #22 stated it had happened a few times in the past but not often. During an interview on 03/25/2024 at 10:00 a.m., LVN D stated on 03/24/2024 at 11:30 a.m., she received a call from the 911 dispatcher stating Resident #22 had called 911 and stated she was sitting in urine and it was burning her skin. She stated the 911 dispatcher said Resident #22 stated she had not been changed since the night before. LVN D stated she went to the room of Resident #22 and the smell of ammonia was so strong it made her eyes water. She stated Resident #22 was saturated in brown urine stains on her diaper, on her sheets and someone had tucked 2 towels between her legs and under her and they were also brown with urine. She stated she cleaned Resident #22 herself and applied moisture barrier cream. She stated there was no noted skin damage from sitting in urine for so long. LVN D stated she located the CNA assigned to Resident #22. LVN D stated CNA E was on her lunch break and stated that she had not had time to get to Resident #22 yet. CNA E stated she had not put the towels between Resident #22's legs that it must have been the night shift CNA. LVN D stated she wrote CNA E up and notified the DON. LVN D stated she called the night shift CNA and nurse and they both denied putting towels between Resident #22's legs and stated she was last cleaned up around 5:15 a.m. LVN D stated she noted increased confusion with Resident #22 while doing incontinent care and she was concerned because there was fecal matter on the towels tucked between her legs too, so she contacted the hospice nurse to come and evaluate Resident #22. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/2024 at 1:00 p.m., CNA E stated she had not gotten to do incontinent care on Resident #22 prior to going to lunch. She stated she would have normally cleaned her up before she went on break, but the facility had been preaching everyone must take their lunch break, so she felt obligated to go. CNA E stated she was terminated related to the incident with Resident #22 and she now understood she needed to make her residents the priority when she was working. During an interview on 03/27/2024 at 10:00 a.m., Hospice RN F stated she was notified of the incident with Resident #22 around 2:00 p.m. on 03/24/2024. Hospice RN F stated LVN D was concerned that a possible UTI could be starting for Resident #22 because she noted increased confusion and she had sat in urine and feces-soaked cloth for an undermined amount of time. Hospice RN F stated she assessed Resident #22 around 3:30 p.m. on 03/24/2024 and noted the increased confusion and the foul odor to Resident #22's urine. Hospice RN F stated she called the MD and he ordered for Hospice RN F to collect a urine sample for a urinalysis with culture and to start Resident #22 on an antibiotic after the sample was collected. Hospice RN F stated it was standard practice for hospice residents to be started on an antibiotic prior to the culture if they were symptomatic. During an interview on 03/28/2024 at 11:00 a.m., the DON stated it was her expectation that all incontinent residents have incontinent care provided to them no longer than every two hours and more frequently than that if time allowed. The DON stated it was not acceptable to use towels to soak up the urine that diaper could not hold between changes. The DON stated frequent incontinent care was important for skin protection and to decrease urinary tract infections. During an interview on 03/29/2024 at 11:00 a.m., the ADM stated he expected all incontinent rounds to be done in a timely manner. The ADM stated he expected the CNA notify the DON or ADM if they were unable to get incontinent care done on all residents assigned to them prior to their lunch break. The ADM stated proper incontinent care was good for skin integrity, psychosocial well-being and to decrease the chance of urinary tract infections. Review of a facility Urinary Infection/Bacteriuria-Clinical Protocol policy revised June 2014 indicated, keeping skin clean and comfortable is a crucial part of incontinence management. Doing so prevents common infections, such as urinary tract infections. While these infections are relatively common, those with incontinence have a higher susceptibility to infections, which can lead to further complications if left untreated.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44596 Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN coverage. The facility failed to provide RN coverage for 8 consecutive hours daily on 10/07/2023, 10/08/2023, 10/21/2023, and 10/22/2023. The deficient practice had the potential to affect residents in the facility by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters. Findings include: Record review of nursing staff information sheets dated 10/07/2023, 10/08/2023, 10/21/2023, and 10/22/2023 indicated that the facility did not have an RN in the facility that worked 8 consecutive hours. During an interview on 03/26/2024 at 10:50 a.m., the DON said the facility had a hard time getting RN coverage at that time but she had been working the weekends since she began in March 2024 to ensure they had coverage. The DON said not having RN coverage left the facility with no supervisory nurse on those days. During an interview on 03/29/2024 at 11:00 a.m., the Administrator said he was unaware the facility had no RN coverage in October 2023. The Administrator said he was not employed by the facility until recently and had no issues with RN coverage had occurred since he began. The Administrator said he was aware having an RN was a requirement. Review of an undated policy titled Nurse Requirements in Nursing Facilities revealed The requirements for long-term care facilities require that nursing facilities provide 24-hour licensed nursing, provide a Registered Nurse (RN) for eight (8) consecutive hours a day, seven (7) days a week, and that there be a RN designated as Director of Nursing on a full-time basis. Record review of Appropriate Nurse Staffing Levels for U.S. Nursing Homes (10/10/2023), www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494 was assessed on 10/11/2023 indicated US nursing homes are required to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident . nursing homes must take into account the resident acuity to assure they have adequate staff levels to meet the needs of residents .the impact of registered nurses (RN) is particularly positive .higher RN staff levels are associated with better resident quality in terms of fewer pressure ulcers; lower restraint use; decreased infection; lower pain; improved activities of daily living independence; less weight loss; dehydration .higher nurse staffing levels in nursing homes and reduced emergency room use and rehospitalization .		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to ensure each resident received necessary behavioral health care services to maintain the highest practicable mental and psychosocial wellbeing for 1 of 3 residents (Resident #38) reviewed for behavioral services. The facility did not ensure Resident #38 was seen after a counseling evaluation and treatment order was placed on 02/15/24 and a psych evaluation referral was signed by Resident #38 on 03/04/24. The facility failed to comprehensively address Resident #38's behaviors and mental distress. The facility failed to update Resident #38's care plan to reflect her increased anxiety medication needs and behaviors. An IJ was identified on 03/28/2024 at 3:45 p.m. While the IJ was removed on 03/29/2024 at 12:41 p.m., the facility remained out of compliance at a scope of a pattern with a potential for with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for the lack of behavioral health services with the potential for emotion trauma, mental distress, and adjustment issues. Findings include: Record review of Resident #38's face sheet printed 03/25/24 indicated Resident #38 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including transient cerebral ischemic attack (is a temporary blockage of blood flow to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) affecting left non-dominant side, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #38's quarterly MDS assessment dated [DATE] indicated Resident #38 was understood and understood others. The MDS indicated Resident #38 had adequate hearing, clear speech, and adequate vision. The MDS indicated Resident #38 had a BIMS score of 13 which indicated intact cognition. The MDS indicated Resident #38 did not have behaviors such as psychosis or physical or verbal behavioral symptoms. The MDS indicated Resident #38 rated going outside to get fresh air when the weather was good as not very important. The MDS indicated Resident #38 upper extremity limitation in range of motion on one side of the body. The MDS indicated Resident #38 admission performance requirement was maximal assistance for putting on footwear, lower body dressing, and toilet hygiene and moderate assistance for oral hygiene, shower/bathe self, upper body dressing, and personal hygiene. The MDS indicated Resident #38 received antianxiety and antidepressant medication during the last 7 days of the assessment period. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #38's care plan dated 03/09/24, edited on 03/11/24 indicated CNA stated that Resident #38 expressed thoughts of harming self: Resident #38 was in her room with a pair of scissors, and it appears that she was trying to stab herself. Resident #38 stated that she had never thought of anything like that. And she was upset that the CNA even thought that. Interventions created on 03/11/24 included: *Nurse to assess mood and behaviors every shift and document findings. *Social services to assess mood and behavior and document findings. Record review of Resident #38's care plan dated 03/03/24, edited on 03/05/24 indicated Resident #38 had the potential for elopement. Intervention included: *Move room closer to nurse's station redirect resident to courtyard area if wanting to go outside. *Attempt to make resident feel secure/safe within facility. Record review of Resident #38's care plan dated 02/14/24, edited on 03/18/24 indicated: *Resident #38 received antidepressant medication for depression. Resident expresses feeling of depression due to long term care transition. Intervention included SW met with resident and referred to Carousel counseling (03/04/24). *Resident #38 received Ativan (antianxiety) for anxiety. On 02/21/24, Resident #38 received Buspirone (antianxiety) tablet for anxiety. The care plan did not indicate several dose changes to the Buspar due to increased anxiety. The care plan did not mention Resident #38's call to 911 due to anxiety. Record review of Resident #38's progress notes by LVN L dated 02/15/24 at 1:45 p.m., indicated .received psych orders to eval and treat from NP HH .increased Buspar (Buspirone) 10 MG BID . Record review of Resident #38's progress notes by LVN L dated 02/15/24 at 2:54 p.m., indicated .Resident #38 called 911 for herself and stated she wanted to go to the ER .Resident #38 has severe anxiety and has complaints of UTI .Notified NP HH and stated patient can go at her request .EMS arrive at 1500 . Record review of Resident #38's progress notes by LVN E dated 02/18/24 at 6:29 a.m., indicated .sn [LVN E] noted resident in floor face down in right side of bed with call light wrapped around neck 4 times .sn[LVN E] asked resident what happened resident stated she trying to get call light undone and kept wrapping it around and somehow fell .no injuries noted .no abnormalities/deformities noted .sn [LVN E] and cna assisted resident back to bed via Hoyer lift .prn pain pill administered po .residents family member notified .DON notified .NP notified by fax .neuros initiated .edited by: LVN E on 02/19/24 10:04 AM Reason: Incorrect data . (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #38's progress notes by LVN E dated 02/18/24 at 6:29 a.m., indicated .sn [LVN E] noted resident in floor face down in right side of bed tangled in call light .sn [LVN E] asked resident what happened resident stated she trying to get call light undone and kept wrapping it around and somehow fell . no injuries noted .no abnormalities/deformities noted .sn[LVN E] and cna assisted resident back to bed via Hoyer lift .prn pain pill administered po .residents son notified .don notified .NP notified by fax .neuros initiated . Record review of Resident #38's progress notes by LVN L dated 02/19/24 at 12:02 p.m., .received new orders to increase Buspar to 10 mg 1 PO TID related to increased depression, RP notified, and orders updated . Record review of Resident #38 progress notes by LVN L dated 02/21/24 at 12:03 p.m., .Resident #38 complained of increased anxiety .notified NP HH .received new order for 1 x dose Ativan 0.5mg now for agitation . Record review of Resident #38's progress notes by LVN KK dated 02/23/24 at 3:35 p.m., indicated .Resident #38 had a crying episode and stated it was because she had an upsetting phone call with her son being mean to her . Record review of Resident #38 progress notes by LVN U dated 03/03/24 at 7:25 p.m., indicated .Resident #38 up in wheelchair, sitting inside building at the back door on the long hall .This nurse [LVN U] encouraged resident to stay inside and to notify staff if she wanted to go out .Resident #38 verbalized understanding . Approx 20 mins later, CNAs notified this nurse that they opened the door for a group of family members and noticed Resident #38 sitting outside in the driveway .Resident #38 questioned why she went outside, she stated, well, I just wanted to get a little fresh air. I wasn't going anywhere . Record review of Resident #38's progress notes by SW dated 03/04/24 at 12:07 p.m., .Resident #38 stated she is having a hard time with her new discharge plan of long-term care but has not desire to leave the facility .SW discussed a referral to local counseling provider .Resident #38 agreed to the referral . Record review of Resident #38's progress notes by LVN R dated 03/09/24 at 11:38 a.m., indicated .8:30 am . CNA [CNA S] reported to this nurse [LVN R] that found Resident [Resident #38] in her room with a pair of scissors and it appeared that she was trying to stab herself .CNA[CNA S] stated that she grabbed the scissors from the Resident and asked what are you doing? .and Resident [#38] stated I was trying to kill myself .CNA [CNA S] gave the pair of scissors to this nurse [LVN R] .the nurse went into Residents [#38] room to interview her to get her side of the story .resident [#38] stated she did not try to stab herself, and that she would never try to kill herself and that she does not have the guts to do that .DOCR went in to get a statement from resident and resident told her the same thing, that she would not ever try to kill herself . Record review of Resident #38's progress notes by the SW dated 03/19/24 at 4:55 p.m., indicated .Resident #38 discussed her difficulty with transitioning to long term care .stated she [Resident #38] didn't have anything to live for now that she is here in the facility .stated that she [Resident #38] had no plan to harm herself .she expressed her sadness about being away from her home and dog .she[Resident #38] said that the only thing she has to look forward to is the food . (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #38's local counseling service provider prepared by SW, dated 03/04/24 indicated .reason for referral: depressive symptoms and anxiety .referral/treatment consent form and doctor's order need to be completed PRIOR TO provision of services and COPY OF EACH FAXED to .Corporate Office . along with a current face sheet .please assure there is an order reads similar to: Please refer to .Evaluation and Treatment . Record review of Resident #38's General Order dated 03/11/24 at 7:45 p.m., by the Interim DON indicated . Refer to local counseling service provider for evaluation and treatment . Record review of a local counseling service provider NP medication review for Resident #38 dated 03/11/24 at 8:00 p.m., indicated .staff requesting patient [Resident #38] to be seen for services due scissors and statement about death .telemed .anxiety level 5 (1-low 10-high) .mood level (1-poor 10-good) .thought process: other .motor activity: other .affect: other .suicidality: none .insights: fair .impulse control: fair . judgement: fair .discontinue one on one .patient [Resident #38] not suicidal .will monitor any changes . No recommendation chosen (medication change or therapy). Record review of Resident #38's local counseling psychological evaluation dated 03/13/24 indicated .the resident was referred for mental health services due to depressive symptoms and anxiety .mood: depressed mood/apathy, anxiety, loss of interest/withdrawal, helplessness, loss of energy/motivation, hopelessness . affect: restricted .recommend therapy (16-60 min 1x per/wk) . During an interview and observation on 03/25/24 at 10:55 a.m. Resident #38's room was dark and quiet. Resident #38 said she had no complaints about the facility, and nothing had happened in her bathroom recently. No fall mat was at her bedside. During an interview and observation on 03/26/24 at 11:04 a.m., Resident #38's room was dark and quiet. Fall mat noted on left side of the bed. Resident #38 said the facility added it yesterday because she had a little incident and fell out of the bed. She said the fall mat was something soft in case she fell out of the bed again. She said it had been a bad morning that day. She said CNA S had found her the wheelchair headed out the room not properly dressed. She said she did not attempt suicide with scissors. She said she was reaching for her hairbrush in the nightstand drawer and picked up the scissors instead. She said CNA S asked why she had the scissors and she told her she found them in the drawer. She said she did suffer depression and anxiety but was on medication for it. She said she really missed her dog. She said her was a certified support dog and wanted to have at the facility full time. During an interview on 03/26/24 at 4:45 p.m., CNA S said she was picking up lunch trays and looked in Resident #38's room and saw her stabbing at her stomach with scissors. She said she asked her what she was doing, and she threw the scissors in the drawer. She said Resident #38 said If it was a knife, I would have been able to cut my throat with it! She said Resident #38 put her foot up against the drawer so she could not get the scissors. She said she told Resident #38 she had to get the scissors and had to let the nurse know what was going on. She said Resident #38 said If you tell on me, I will say you hurt me! She said Resident #38's foot slipped from the drawer enough for her to get the scissors. She said she took the scissors to LVN R. She said LVN R said she would take care of it. She said Resident #38 had made other comments about hurting herself before. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/27/24 at 10:04 a.m., a family member of Resident #38 said he had been informed of his family members voiced suicide attempts. He said when Resident #38 got out the back door on 03/03/24 without permission, she later texted him saying she wanted to walk into traffic. He said he thought he told the case worker Resident #38 made that statement. He said Resident #38 did not have a history of suicidal ideations. He said his family member wanted to come home, but he could not care for her anymore. During an interview on 03/27/24 at 11:39 a.m., the SW said Resident #38 was anxious and depressed when she first admitted to the facility. She said she was initial supposed to go back home but changed plan and she was staying for long term care. She said Resident #38 had some adjustment issues but was on medication and psych services. She said Resident #38's family member never reported to her about her texting him she wanted to walk into traffic. She said Resident #38's family had reported attention seeking behaviors like constantly calling and how she had ruined relationships with her behavior. She said Resident #38 family member said Resident #38 would not harm herself, it was just attention seeking and she would not do it. She said she was not notified of the incident on 03/09/24 until Monday, 03/11/24, when she returned for work. She said she assessed Resident #38 on 03/11/24 and she did not make any comments of self-harm. During an interview on 03/27/24 at 12:59 p.m., LVN R said she was agency staff but had worked with Resident #38 often. She said Resident #38 had never told her she was depressed. LVN R said she went to speak to Resident #38 after CNA S brought her the scissors and told her Resident #38 tried to harm herself with them. She said CNA S told her she took the scissors from Resident #38 and asked her what she was doing. She said the first time, CNA S said Resident #38 said I don't know or I'm not doing anything. She said she went to speak with Resident #38, and she said CNA S was mad at her because she did not want to assist her to the restroom. She said Resident #38 said she would never harm herself or have the guts to do it. She said she assessed Resident #38's stomach and there were no marks or anything. During an interview on 03/28/24 at 8:40 a.m., LVN E said on 02/18/24, Resident #38 fell out of her bed. She said Resident #38 said she was trying to get the call light cord and rolled out of the bed. She said Resident #38 did have the cord wrapped around her neck four times when she found her. She said there were no marks on Resident #38 neck after the fall. She said she did not modify her nursing note to state tangled instead of wrapped around neck. She said she believed what Resident #38 said because she was confused, and her room was dark when she arrived. She said she did not think Resident #38 was trying to harm herself. She said she did not know what interventions were put in place after that incident on 02/18/24 because she was agency staff then. During an observation on 03/28/24 at 9:00 a.m., Resident #38 was lying down in a dark room asleep. During an interview on 03/28/24 at 9:15 a.m., LVN L said she had taken care of Resident #38. She said when Resident #38 was first admitted, her anxiety and depression seemed to progressively get worse every time she worked. She said she had to contact NP HH several time about Resident #38 anxiety. She said Resident #38 wanted to go to the hospital because her anxiety was so bad. She said Resident #38 was having a hard transition from being at home with her son to now in a nursing home. She said she did stay in her room a lot but was normally in pleasant mood. She said she tried to assess Resident #38 mood and address what may be causing the issue. She said Resident #38's care plan should mention her recent medication changes and behavioral issues. She said the care plan would show what had worked and if Resident #38 was improving or not. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/28/24 at 4:30 p.m., the SW said the psych treat and evaluation order placed on 02/15/24 was done without a discussion between the morning meeting. She said normally referrals were discussed between her and NP HH. She said then the referral was sent by fax or email to the local counseling provider. She said she preferred doing it by email. She said on 03/04/24, she did a well check and got consent for an evaluation. She said the local counseling provider normally took less than 3 weeks to see residents for services. She said telehealth could be used if needed for some residents. She said medication management was normally done by NP GG. And a Psychologist normally did the evaluations. She said the facility had a licensed counselor that served the facility. She said she did not believe the delay in psych service contributed to Resident #38's self-harming incidents. She said Resident #38 just wants to go home. On 03/29/24 at 9:46 a.m., attempted to contact NP HH by phone and text message. No response before or after exit. During an interview on 03/29/24 at 12:19 p.m., the interim DON said she was not aware of Resident #38's incident on 02/18/24. She said it looked like they tried to cover it up. She said she was also not aware of Resident #38 telling her son she wanted to walk into traffic. She said the Suicide policies should have been followed for Resident #38's incidents. She said the Suicide policies were not new and staff had been re in serviced. She said Resident #38 was able to be seen on Telemed by NP GG who determined she could come off 1:1 monitoring. She said the psych referral process had always been the same and the SW was terminated for not completing them social service duties. She said it was important to take all reports of threats seriously and addressed right way to prevent something from happening. Record review of an undated facility's Behavioral Assessment, Intervention and Monitoring policy indicated . behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment .the nurse staff will identify, document, and inform the physician about specifics details .new onset or change in behavior will be documented regardless of the degree of risk to the resident . cause identification .emotional. Psychiatric and/or psychological stressors .functional, social or environmental factors .management .the care plan will incorporate findings from the comprehensive assessment . monitoring . Record review of an undated facility's Processing Psych Referrals policy indicated .nurse receives order for psych referral and enters matrix order .nursing to notify social services of needed referral and discuss in daily C.A.R.E meeting to ensure need for referral is communicated .social services will complete referral form/consents as required for psych referral and submit to psych provider in a timely manner .social services to follow up on resident until psych provider visit is made . The Interim ADM and Interim DON was notified this was determined to be an Immediate Jeopardy (IJ) on 03/28/24 at 3:45 p.m The Interim ADM was provided with the IJ template on 03/28/24 at 3:45 p.m. The POR was accepted on 03/29/24 at 11:07 a.m., and indicated the following: Plan of Removal F740 Immediate Actions: The Medical Director was notified of the immediate jeopardy on 3/28/2024. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The resident #38 was seen on 3/09/2024 by Carousal Counseling. An emotional support visit was completed on 3/28/2024 with resident #38 and the resident was assessed for continuing thoughts of self-harm. This visit was completed by the corporate social worker. Abuse Coordinator contact information and Mandatory Notification requirements were confirmed posted at each nursing station for staff use on 3/28/2024. Resident #38's record was reviewed. The care plan was updated for the events on 2/18/24 and 3/3/24. The resident continues on weekly psychotherapy with a licensed psychologist. The provider was notified of these two events by the corporate social worker. Residents, including resident #38, were assessed to ensure no other residents were having suicidal ideations/mental distress on 3/28/2024 and 3/29/2024 by members of the corporate team, including regional nurse consultant, acting administrator and regional reimbursement director. An audit was completed to ensure all orders for psych referrals were completed. Orders for the past 60 days were reviewed. This audit was completed on 3/28/2024 by the corporate social worker. The social worker was terminated on 3/28/2024. The administrator was terminated on 3/26/2024. The previous DON was terminated on 3/08/2024 related to issues leading up to the survey. Education Provided: Direct care staff were educated on Mandatory Notifications to the facility abuse coordinator. Mandatory Notifications include Resident, Environmental and Other extraordinary events that pose a risk to resident safety, among other things. Suicidal Ideations / Attempts are included in this in-service. Direct care staff were educated on Suicide Prevention Management Policy and Procedure, which includes an overview of the steps the facility should enact in the event of suicidal ideations / attempts. These include required notifications, immediate protections and other actions required. Nursing management and social services were in-serviced on the process for managing, communicating, and completing psych referrals timely, including during the daily CARE Meeting. The social worker is responsible for ensuring psych evals are completed timely. The CARE meeting is performed by nurse management and is a review of the previous day(s) activity, including a review of nurse's notes, new orders, any events and the 24-hour report during the period reviewed. Items that require follow-up are noted and tracked until completion, including any ordered psych referrals. The ADONs, with oversight from the corporate social worker, will oversee this process in absence of a social worker. These in-services will be given by the Director of Nursing or designee starting on 3/28/2024 at 5:00PM and completed on 3/29/2024 by 12:00PM. Any staff who haven't been educated by that time will not be allowed to work until education is completed. The DON was educated by the acting administrator and corporate social worker on 3/28/2024. Policies reviewed include the Suicide Management Precaution Policy and Procedure and Abuse Prevention Program. The Psych Referral Process was updated on 3/28/2024. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/29/24, Five surveyors confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of Resident #38's Carousel Counseling note. Resident #38 was seen on 03/11/24, 03/13/24, 03/19/24, and 03/26/24 (Resident #38 cancelled her session due to pain). Record review of Resident #38's Corporate SW note dated 03/28/24. Resident #38 denied feelings of depression or anxiety at the time. Corporate SW spoke with NP GG this evening to request a follow up visit with resident. Record review of Resident #38 care plan dated 03/09/24, edited on 03/29/24 indicated added information of incidents on 02/15/24 (call 911 wanting to go for anxiety), 02/18/24 (Resident noted in floor with call light around neck), and 03/03/24 (found outside in parking lot). Interventions also updated to reflect Carousel Counseling visit and increase Buspar on 02/15/24. Record review of an audit of 60 residents Mood Assessments. Six resident expressed mental distress or depression. Facility has follow up in place for residents. Record review of an audit of 60 resident assessing Carousel Services in place. No issues noted. Record review of the previous SW termination letter dated 03/28/24. Termination of employment due to failed to perform social services duties by failure to complete psych reports as required. Record review of the previous ADM termination letter dated 03/27/24. discharged due to failure to perform Administrator duties. Record review of the previous DON termination letter dated 03/08/24. discharged due to failure to perform Director of Nursing duties. Record review of an In-Service Form indicated for direct care staff dated 03/28/24-03/29/24. The in-service was presented by the [NAME] President of Clinical Operation. The Topics was Abuse Prevention Program. The policy included the seven components: prevention, screening, identification, training, protection, reporting/responding, and investigation. Record review of an In-Service Form indicated for direct care staff dated 03/28/24-03/29/24. The in-service was presented by the [NAME] President of Clinical Operation. The Topics was Suicide Precaution Policy and Procedure. The policy included intervention to start, who to contact, and what to chart. Record review of an In-Service Form indicated for direct care staff dated 03/28/24-03/29/24. The in-service was presented by the [NAME] President of Clinical Operation. The Topics was Mandatory Notifications. The policy included when to notify the facility administrator and DON and what events to report. Record review of an In-Service Form indicated for direct care staff dated 03/28/24-03/29/24. The in-service was presented by the [NAME] President of Clinical Operation. The Topics was Psych Referral Process. This policy included how to initiate a psych referral, step by step process, who was responsible, and the provider the facility used with phone number. (continued on next page)		

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation 03/29/24 at 11:22 a.m., posted Abuse Coordinator signs at nurse's station. Abuse Coordinator was the Interim ADM. During interviews conducted on 02/29/24 beginning at 11:20 a.m. through 12:25 p.m., 40 of 69 direct care in-serviced (including staff across all shifts that were upper management, AD, Treatment Nurse, MDS Coordinator, and Maintenance) were interviewed. All staff said they received education on the Abuse Prevention Program, Mandatory Notifications, Suicide Precaution Policy and Procedure, and Psych Referrals (Nurses). All staff said they received education on resident environmental and other extraordinary events that pose a risk to residents' safety, among other things, suicidal ideations/attempts, steps the facility should enact in the event of suicidal ideations/attempts, required notifications, immediate protections and other actions required, processing for managing, communicating, and completing psych referrals timely. All staff reported they would report all reports of suicidal ideation to the charge nurse, DON, and ADM. All staff reported they would not leave the resident alone until another staff member arrived. All staff reported they would remove all harmful items from the resident's room. Nursing staff reported they would document every 4 hours while the resident was on 1:1 monitoring, and the CNA staff said they documented every 15 mins. Nursing staff said when a counseling service order was placed, they would follow the psych referral process. During an interview on 03/29/24 at 12:21 p.m., the Interim DON said she was in-serviced by the Interim ADM on the Abuse Prevention Program. She said the facility was required to report to the State within 2 hours for abuse allegation. She said the facility's policy should be followed to protect the residents. She said suicide policy and procedure should be followed. She said mandatory events should be reported to the facility ADM and DON such as abuse allegation and suicide attempts. She said psych referrals will be followed through and discussed in the C.A.R.E. meetings. She said the facility performed mood assessments on all the residents and would address any signs of mental distress. The Interim ADM, DOCR, Corporate SW, and Regional Nurse were informed the Immediate Jeopardy was removed on 03/29/24 at 12:41 p.m., the facility remained out of compliance at a scope of a pattern with a potential for with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 13 residents (Residents #46 and Resident #23) reviewed for pharmacy services. The facility failed to ensure medications were administered timely for Resident #46 and Resident #23. This failure could place residents at risk for inaccurate drug administration and overdosing of medications. Findings include: 1. Record review of Resident #46's face sheet, dated [DATE], reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #46 had diagnoses which included COPD (is a group of long-term lung conditions, including emphysema and chronic bronchitis), pneumonia (infection of the air sacs in one or both the lungs) and neoplasm of the lung (tumors that form either from lung tissue, also known as a primary neoplasm, or from the distant spread of cancer from another part of the body). Record review of Resident #46's quarterly MDS assessment, dated [DATE], reflected Resident #46 required extensive assist of one staff for transfer and toileting. Resident #46 had a BIMS of 15, which indicated no cognitive impairment. Record review of Resident #46's care plan, dated [DATE], titled Other reflected Resident #46 had chronic bronchitis and was at risk for wheezing, cough, and shortness of breath. The intervention listed was to administer inhalers as ordered. Record review of Resident #46's MMD orders, dated February 2024, reflected Resident #46 was to receive Symbicort inhaler twice daily ordered on [DATE]. On [DATE] the order for Symbicort was discontinued and an order for Brenya inhaler was ordered twice daily at 8:00 a.m. and 8:00 p.m. Record review of the MAR, dated February of 2024, reflected Resident #46 missed doses of Symbicort on [DATE], [DATE], [DATE], [DATE] and [DATE]. Record review of the MAR, dated March of 2024, reflected Resident #46 missed doses of Brenya on [DATE], [DATE], [DATE] and [DATE]. Record review of a grievance, dated [DATE], reflected Resident #46 voiced a concern that she could not get her inhaler on time. The grievance was completed with a resolution of in-servicing the nurses to administer the inhaler on time. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 10:00 a.m., Resident #46 stated she had not received her inhaler all weekend or this morning. Resident #46 stated she needed her inhaler because her chest got tight and it was hard to breath if she missed more than a dose. At 10:02 a.m. ADON G, brought Resident #46's inhaler and assisted Resident #46 with administration of the inhaler. During an interview on [DATE] at 11:00 a.m., the MD stated not having Symbicort or Brenya for a few days was not going to cause any significant damage to the resident. He stated these meds act best if used continuously, but no harm will come to the resident for a few missed doses. 2. Record review of Resident #23's face sheet, dated [DATE], reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #23 had diagnoses which included hemiplegia (a symptom that involves one-sided paralysis), congestive heart failure (a long-term condition when your heart can not pump enough blood to keep up with your body's demand) and pain. Record review of Resident #23's quarterly MDS assessment, dated [DATE], reflected Resident #23 had a BIMS of 10, which indicated a moderate cognitive impairment. Resident #23 required limited assistance of one staff member for ADLs such as toileting and transfer. Record review of Resident #23's care plan, last updated [DATE], titled pain indicated Resident #23 received routine hydrocodone every 4 hours. Resident #23 will voice that she does not receive the medication in a timely manner. The intervention is to administer the hydrocodone in a timely manner. Record review of the MD orders, dated [DATE], reflected Resident #23 had an order for hydrocodone/acetaminophen ,d+[DATE] mg every four hours to be administered for pain. Record review of Resident #23's progress notes, on [DATE], indicated no notification of late administration of medication was made to the MD. During an observation and interview on [DATE] at 9:40 a.m., Resident #23 stated she had not received her hydrocodone due at 7:00 a.m. this morning. She stated the nurses did not wake her to give her the one due at 3:00 a.m. because she was asleep at that time. Resident #23 stated the last hydrocodone she received was on [DATE] at around 11:00 p.m. Resident #23 stated she was in pain, but it was not a great deal of pain. At 9:45 a.m., MA G entered the room and administered all of Resident #23's medication which included the 7:00 a.m. scheduled hydrocodone. MA G stated she did the best she could to get all the medications passed in a timely manner but it was not always possible to keep in the time frame. During an interview on [DATE] at 10:45 a.m., the DON stated it was the responsibility of the charge nurse to ensure all medications were available to the residents. The DON stated if the facility did not have a medication, the nurse was to contact the ADON or DON and they would follow up to ensure the medication was received. The DON stated as far as the times the medications were administered, she and the ADM had a plan in place to change medication times to ensure the medication aides were able to deliver all medications in a timely manner. The DON stated getting routine medications on time was important to ensure the medication had a therapeutic effect and drug levels were maintained in the blood stream. The DON stated not having therapeutic drug levels could lead to pain in the case of Resident # 23 and shortness of breath in the case of Resident #46 if the resident continued to not receive the medication. The DON stated with Resident #46's Symbicort it was an insurance issue that has been remedied . (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:00 a.m., the ADM said he expected the nurses to communicate with the DON and himself any problems they had getting anything they needed for the residents from clothing to medications and equipment. The ADM stated the facility was working on a plan to ensure medications were administered on time. The ADM stated the facility would have paid for Resident #46's Symbicort if he had known about it. Record review of the facility policy, dated [DATE], titled Administering Medications reflected, Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interview and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record and residents who use psychotropic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in and effort to discontinue these drugs for 3 of 17 residents, (Residents #56, #28, and #50) reviewed for unnecessary medications. 1.The facility failed to ensure Resident #50 received a gradual dose reduction for her Ziprasidone (antipsychotic). 2.The facility failed to ensure Resident #28 received a gradual dose reduction for his Risperdal (antipsychotic). 3.The facility failed to have an appropriate diagnosis or indication of use for Resident #56's Seroquel (antipsychotic). These failures could place residents at risk of receiving unnecessary psychotropic medications, risk of dependence on psychotropic medications, complications of prolonged use, and decreased quality of life. Findings included: 1.Record review of Resident #50's undated face sheet reflected Resident #50 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses that included: Vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain), senile degeneration of the brain (severe cortical atrophy and cell loss with a high index of dementia), Type 2 Diabetes (a problem in the way the body regulates and uses sugar), pain, dementia, severe with anxiety (loss of cognitive functioning with anxiety from the confusion and disorientation). Record review of Resident #50's significant change MDS, dated [DATE], indicated Resident #50 had clear speech, was sometimes understood, and sometimes understood others. She had short-term and long-term memory problems. Resident #50 was taking an antipsychotic. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #50's undated care plan reflected Resident #50 had poor safety awareness and forgot limitations increasing the risk of falls related to impaired cognition, received antipsychotic medication once daily and was at risk for motor and sensory instability, postural hypotension, leading to falls, fractures, or other injuries. One of the approaches on the care plan dated 2/6/24, was to Attempt a GDR in 2 separate quarters the first year medication is received, unless clinically contraindicated. Attempt yearly GDR there after unless clinically contraindicated. Another approach was to monitor the resident's behavior and response to medication and a pharmacy consultant review. Resident #50 was at risk for adverse consequences related to receiving antipsychotic medication for treatment of psychosis. She had difficulty understanding others related to impaired cognition related to dementia. Record review of Resident #50's undated physician's orders reflected the following: -7/12/23 Ziprasidone (Brand name, Geodon) HCL capsule, 20 mg, 1 tablet, oral for unspecified psychosis. -8/11/23 Antipsychotic medication use - observe resident closely for significant side effects: Common-Sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. -8/11/23 Target behavior: (Dementia symptoms with severe anxiety). At the end of each shift mark frequency-how often behavior occurred and intensity-how resident responded to redirection. (New orders, completed after surveyor intervention.) -3/27/24 D/C Ziprasidone. -3/27/24 Depakote ER (divalproex) tablet extended release 24- hour, 250 mg, 1 tab twice a day. -3/27/24 Venlafaxine tablet 37.5 mg twice a day. -4/12/24 Depakote level (in 2 weeks). -7/12/24 Depakote level (every 3 months). Record review of Resident #50's MAR for January 2024, February 2024 and March of 2024 indicated Resident #50 had Ziprasidone HCL capsule, 20 mg, 1 tablet daily for unspecified psychosis. She was being monitored for antipsychotic use. Record review of Resident #50's pharmacy recommendation dated 9/29/23 indicated : Current order: Geodon 20 mg, PO, once daily for dementia with anxiety. Proposed order: D/C Geodon. Geodon PO once every other day for 2 weeks, then D/C to determine continued need for antipsychotic use. Record review of Resident #50's pharmacy recommendations for 8/2023 through present 3/2024 did not indicate a recommendation to reduce or D/C Geodon (Ziprasidone). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Clinical Services note for Resident #50, dated 3/11/24 indicated an order to D/C Geodon and start Venlafaxine 37.5 mg PO twice a day, and Depakote 250 mg PO twice a day . 2.Record review of Resident #28's undated face sheet reflected a [AGE] year-old male who was admitted to the facility 1/14/21 and readmitted [DATE]. Resident #28 had diagnoses that included: Vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain), altered mental status (acute change in arousal and content), seizures (sudden uncontrolled body movements that occur because of abnormal electrical activity in the brain), and Bipolar Disorder (serious mental illness that causes shifts in mood). Record review of Resident #28's annual MDS dated [DATE], reflected Resident #28 had clear speech, was sometimes understood by others, and sometimes understood others. He had a BIMS score of 4, which indicated severe cognitive impairment. Resident #28 was taking an antipsychotic medication. Record review of Resident #28's undated care plan reflected Resident #28 had vascular dementia and used psychotropic drug use for depressive bipolar disease. The care plan was not noted to indicate a GDR was part of the goals or approaches. The care plan indicated he had cognitive loss and dementia. Record review of Resident #28's undated physician's orders indicated the following: 1/26/23 Risperdal (risperidone), 1 mg, 1 tablet twice a day, oral. Record review of Resident #28's pharmacy recommendations indicated the following: -2/26/23 Risperidone, failed dose reduction 7/21. -4/27/23 Risperidone, failed dose reduction 7/21. -9/29/23 Please evaluate resident for trial dose reduction. A Consultant Pharmacist/Physician communication, dated 9/29/23, with the proposed order to decrease Risperdal to 0.5 mg PO bid was blank, and was not signed by the MD. -11/30/23 Risperidone, failed dose reduction 7/21. Record review of Resident #28's Clinical Services dated 3/11/24, indicated the following: -Decrease Risperdal 1 mg PO at bedtime for 1 week then D/C. -D/C Lexapro -Venlafaxine 37.5 mg PO twice daily -Depakote 250 mg PO twice daily -Depakote level in 2 weeks, then every 3 months. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/24 at 1:11 PM, the Consultant Pharmacist said CMS had 5 diagnoses that were approved for long term psychotic use : Bipolar Disorder (mood swings with manic highs and lows), Schizophrenia (breakdown in thought, emotion, and behavior), Huntington's Disease (neurons in the brain breakdown and die), Delusional Disorder (unable to tell what is real and what is imagined), and Refractory Depression (does not respond to traditional and first-line therapeutic medications). She said GDR's were excluded by CMS and to request a GDR would be irresponsible on her part. She said antipsychotic's were not appropriate for the diagnosis of dementia. She said Resident #50 and Resident #28 were not appropriate for a GDR due to their diagnoses. She said overmedicating residents was a terrible problem but to reduce medications that were working for those diagnoses could cause many problems. During an interview on 3/27/24 at 3:30 PM, the DON said they were going to d/c Geodon for Resident #28. She said she did not see a GDR for Resident #28 or Resident #50. She said for Resident #50 the pharmacy consultant book only indicated when the medication (Ziprasidone) was ordered. She said there was not a GDR requested for Resident #50 or Resident #28. During an interview on 3/27/24 at 4:19 PM, the DON said ADON C had Resident #28's Clinical Services order, called the family and they disagreed with the recommendation from Clinical Services so they did not do anything else with it. She said she just now (3/27/24) saw the Clinical Services order for Resident #50 and had acted on the order. During an interview on 3/28/24 at 7:31 AM, LVN D said antipsychotics, antidepressants, antianxiety , and hypnotic medications should be the smallest effective dose for the least amount of time to treat the resident. She said a dose reduction should be done when possible because you did not want residents to get side effects and wanted the resident to get better. During an interview on 3/28/24 at 7:41 AM, LVN E said the goal with antipsychotics, antidepressants, antianxiety, and hypnotic medications was to use the least amount of medications for the shortest time . During an interview on 3/28/24 at 7:57 AM, ADON F said any antipsychotics, antidepressants, antianxiety, and hypnotic medications should be used for the least amount of time with the least possible dose to prevent oversedation, falls, or psychosis. He said GDR's should be done safely, if not contradicted and typically should have been done quarterly. During an interview on 3/28/24 at 7:56 AM, the DON said a prior GDR for Resident #28's Risperdal had been refused by his MD a little over a year ago. She said a GDR should have been requested by the pharmacist. She said Clinical Services had given an order for a GDR but the family refused the new orders when ADON C called so they did not request it from the MD because the family would not have signed the consent. She said the GDR for Resident #50 from Clinical Services was missed. She said the new orders were followed now . (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 8:06 AM, the Interim ADM said a GDR should have been requested for Resident #28 even though the family refused, but said he did not know the situation. He said all antipsychotics, antidepressants, antianxiety, and hypnotic medications should be used for the shortest time possible with the lowest dose. He said the Counseling Services order should have been followed for Resident #50 and it was not. He said residents should have a GDR every 6 months. During an interview on 3/28/24 at 8:16 AM, ADON C said she received the GDR from the Clinical Service on 3/12/24 for Resident #28. She said she called the resident's family member and she refused the GDR, actually wanting the medication increased. She said Resident 28's family member refused any new medication. ADON C said she missed the order from the Clinical Services to discontinue Resident #50's Geodon. She said the purpose of a GDR was to get the resident off any said antipsychotics, antidepressants, antianxiety, and hypnotic medications due to side effects. She said the goal was to use the least amount of medication for the shortest amount of time. She said the risk of not getting a GDR was falls, side effects, Tardive Dyskinesia (a condition affecting the nervous system causing involuntary, repetitive movements), and Extrapramidal symptoms (continuous spasms and muscle contractions). 49019 3. Record review of Resident #56's face sheet, dated 3/27/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included Charcot's joint, right ankle, and foot (a disease that attacks the bones, joints, and soft tissue of feet), Acute osteomyelitis, right ankle, and foot (an infection in a bone), Diabetes Mellitus (group of diseases that affect how the body uses blood sugar) and anxiety disorder due to known physiological condition (frequent intense, excessive, and persistent worry or fear about everyday situations). Record review of Resident #56's quarterly MDS, dated [DATE], reflected Resident #56 had a BIM's score of 13, which indicated cognitively intact cognition. Resident #56 was understood and understood others. Record review of Resident #56's active orders, dated 2/23/2024, reflected Seroquel 400 mg give 1 tablet at bedtime. Record review of Resident #56's prescription order, dated 2/23/2024, reflected Seroquel 400 mg 1 tablet at bedtime for diagnosis of Vascular dementia (brain damage caused by multiple strokes), moderate, with anxiety (frequent intense, excessive, and persistent worry or fear about everyday situations). Record review of Resident #56's care plan, dated 3/18/2024, reflected Resident #56 received antipsychotic medication Seroquel per MD orders without diagnosis for use. Resident #56 was to be monitored for behaviors and response to medication. Record review of Resident #56's progress note, dated 3/27/2024, reflected the regional MDS nurse contacted Resident #56's RP for additional information and history of out-patient care received. The Regional MDS nurse contacted the out-patient community clinic and verified a diagnosis of Schizophrenia. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/2024 at 11:35 a.m., Resident #56 said she did not have a diagnosis of vascular dementia. Resident #56 said she was seen prior at an out-patient community psychiatric service and was put on Seroquel. During an interview on 3/27/2024 at 1:04 PM, the MDS nurse said she was a new MDS nurse and she coded vascular dementia from Resident #56's community records. The MDS nurse could not locate the documentation of vascular dementia and said it was not the correct diagnosis. The MDS nurse said she identified the error on the MDS on 4/3/2024. The MDS nurse said the diagnosis should be corrected when identified and did not have a reason why it was not corrected. During an interview on 3/28/2024 at 10:40 a.m., ADON F said vascular dementia was not an appropriate diagnosis for the use of Seroquel. ADON F said the MDS or admitting nurse was the one who completed the assessment based on the community records and history and physical. During an interview on 3/28/2024 at 10:50 a.m., the DON said the MDS nurse coordinator was responsible for completing the MDS and she expected the MDS nurse to complete an accurate assessment. The DON said she expected the charge nurses and staff nurses to verify proper diagnosis for psychotropic medications. During an interview on 3/28/2024 at 10:57 a.m., the [NAME] President of Operations said the charge nurse or MDS nurse completed the admission assessment and nursing staff should verify the diagnosis. The [NAME] President of Operations said he expected the nurses to question inaccurate diagnosis. Record review of the facility policy titled Medication Therapy, revised 11/13/2018, reflected Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks .Medication use shall be consistent with the individual's condition, prognosis .Medication orders will be supported by appropriate care processes and practices .3. Psychoactive drug monitoring . Residents who receive antidepressant, hypnotic, antianxiety or antipsychotic medications are monitored to evaluate the effectiveness of the medication .Residents receive a psychoactive medication only if designated medically necessary by the prescriber .is documented in the residents medical record and in the care plan process .a medical or psychiatric consultation or evaluation supporting confirming physician's conclusion . physician, nurse, or other health professional documentation that the resident is being monitored for adverse consequences or complications of therapy .The consultant pharmacist compiles, analyzes and presents data related to psychoactive drug uses in the facility as a component of the CQI process . Psychoactive drug monitoring guidelines include but may not be limited to .the resident has been diagnosed with one of the following indications, as defines by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition . General anxiety disorder, organic mental syndrome (delirium, dementia and amnestic and other cognitive disorders) with associated agitated behaviors		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review the facility failed to ensure that the medication error rate was not 5 percent or greater. The facility had a medication error rate of 6.06%, based on 2 errors out of 33 opportunities, which involved 2 of 7 residents (Residents #2 and #53) reviewed for medication errors . 1. The facility failed to ensure MA Z administered Resident #2's Artificial saliva (mimics natural saliva and helps provide relief for dry mouth) and failed to ensure the medication was in the facility and available for the resident. 2. The facility failed to ensure LVN P did not crush Guaifenesin 600mg tab (help clear mucus or phlegm from the chest when you have congestion from cold or flu) for Resident #53. These failures could place residents at risk of not receiving the intended therapeutic benefit of their medication or receiving them as prescribed, per physician orders. The findings include: 1. Record review of Resident #2's face sheet, printed 3/28/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Acute on Chronic systolic (congestive) heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), Constipation (is a problem passing stool) and Essential hypertension (high blood pressure that is not due to another medical condition). Record review of Resident #2's quarterly MDS, dated [DATE], reflected Resident #2 was understood and understood others. Resident #2 had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #2 needed moderate assistance with ADL's. Record review of Resident #2 care plan, dated 2/9/24, reflected Resident #2 has potential for dehydration related to diuretic use and Dementia. Record review of Resident #2's physician orders, dated March 2024, reflected Artificial saliva 60ml 1 application orally twice daily. During an observation of the medication pass on 3/26/24 at 8:22 AM revealed MA Z checked the medication cart for Resident #2's artificial saliva. The medication was not on the cart MA Z notified ADON F and he checked the med storage room, but the facility did not have the medication on hand. ADON F said he had to order the medication. During an interview on 3/26/24 at 8:25 AM, MA Z stated the medication should have been given per Physician orders and she did not administer the medication . (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 03/28/24 at 10:42 AM, the Interim ADM said he expected all med carts and nurse carts to be stocked and locked with the correct medications for each resident. The Interim ADM said, if staff got low in medications, staff should inform management to put an order in or go buy the OTC. 2. Record review of Resident #53's face sheet, printed 3/28/24, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #53 had diagnoses which included Pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), Covid-19 (is a contagious disease caused by the SARS-CoV-2 virus) and Gastrostomy status (is a tube inserted through the belly that brings nutrition directly to the stomach). Record review of Resident #53's quarterly MDS, dated [DATE], reflected Resident #53 was understood and understood others. Resident #53 had a BIMS score of 4, which indicated her cognition was impaired. Resident #53 needed total assistance with ADL's. Record review of Resident #53 care plan, dated 2/9/24, reflected Resident #53 had potential exposure to Covid which the resident was in warm unit for contact precautions He required enteral feeding and was at risk for aspiration pneumonia, constipation and dehydration. During an observation of the medication pass on 03/27/24 at 7:15 AM revealed LVN P crushed a guaifenesin 600mg tab and tried to administer medication per gastric tube on Resident #53. The medication was not administered due to the medication clogged at the gastric tube port. During interview on 03/27/24 at 2:51 PM, LVN P said extended-release medications should not be crushed. LVN P said she notified NP AA, the on-call NP, for an order for Resident #53 Mucinex 400mg twice a day per gastric tube. LVN P said Resident #53 was transferred from another unit to her and he already had the order in place . During interview on 03/28/24 at 10:30 AM, the Interim DON said she expected the nurses and MA's to have the correct medications on the cart prior to med pass. The Interim DON said LVN P was educated not to crush an extended-release medication. The Interim DON said she hired a CNA for central supply and she was responsible medications ordered and to stock the med rooms. During interview on 03/28/24 at 10:50 AM, MA G said the nurses were responsible for ordering the medications on the carts, but if she saw a medication was low in quantity she would order it. MA G said she called the pharmacy herself and ordered meds. MA G said she could not order narcotics just regular meds, because the nurse had to order the narcotics. MA G said she informed the nurse when medications got low. MA G said that happened frequently with medications not on hand when she returned to work from her off days. MA G said she guessed that happened because the facility had a lot of Agency who worked. During interview on 03/28/24 at 10:58 AM, ADON C said if a medication was not on hand the MA should notify the nurse as soon as possible. ADON C said the nurse should contact the pharmacy or get the medication from the med room. ADON C said an extended release should never be crushed . ADON C said the nurse should have notified the Nurse Practitioner or Physician and got the order changed to something that could go down the peg.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation. 1. The facility failed to ensure food was properly sealed and not exposed to air in the storeroom and refrigerator. 2. The facility failed to ensure food and drink items were labeled and dated in the refrigerator, freezer, and drink dispenser. 3. The facility failed to ensure raw chicken was thawing in the appropriate sink under constant flow of cool, running water. 4. The facility failed to ensure items were not stored on the floor in the storeroom and back area near refrigerators. 5. The facility failed to ensure the kitchen did not have a splattered brown substance on the walls near industrial mixer. 6. The facility failed to ensure food preparation equipment and drink dispensers were cleaned after use. 7. The facility failed to ensure a black metal shelf holding cookware was 6 inches from the ground. 8. The facility failed to ensure a freezer had a posted [DATE] temperature log. 9. The facility failed to ensure staff consistently completed [DATE] temperature logs for refrigerators and freezers. 10. The facility failed to ensure the dishwasher and compartment sink had the correct amount of chemical solutions. 11. The facility failed to ensure staff consistently completed chlorine strip test results for the dishwasher on the [DATE] log. 12. The facility failed to ensure staff kept a log for the [DATE] temperature of the dishwasher machine. 13. The facility failed to ensure Cook DD did not poke thru clear wrap to check the internal temperature of the food during the lunch meal service on [DATE]. These failures could place residents at risk of foodborne illness and food contamination. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The Refrigerator and Freezer Temperature [DATE] Log labeled Milk Cooler was missing dates for AM shift (, d+[DATE], ,d+[DATE]) and PM shift (,d+[DATE]). During the initial tour in the kitchen on [DATE] at 9:22 a.m., revealed the refrigerator labeled walk in had the following items: *Two large bags of shredded yellow and white food item were not labeled and dated. *One bottle of little brown liquid was not dated. *One box of bananas with no received date. *One box (15 dozen) of eggs with no date. *Six heads of a green leafy vegetable were not labeled and dated. *One large container of cottage cheese was not dated. *One opened box of bacon was not dated. *One clear container with 7 blocks of margarine with a label use by [DATE]. During the initial tour observation in the kitchen on [DATE] at 9:30 a.m., revealed the refrigerator labeled Drink left over cooler had the following items: *One bag of sliced meat was not sealed, labeled and dated. *One container of shredded yellow and white food item was not labeled. *One large container of relish was not dated. *Two containers of thick and easy with use by dates of [DATE] and [DATE]. *One clear container of yellow, crushed food item was not labeled. During the initial tour observation of the kitchen on [DATE] at 9:40 a.m., the dry storage pantry had the following items: *One empty tall box was on the floor. *One box of oil was on the floor. *Two boxes of was apple juice (for the juice dispenser) on the floor. *One box of chips was on the floor. *One box of plastic coffee mugs was on the floor. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial tour observation of the kitchen on [DATE] at 9:58 a.m., revealed the [DATE] Test Strip Log for Three Compartment Sink was missing PPM when used on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] and ,d+[DATE]. During an interview and observation on [DATE] at 11:30 a.m., Cook DD said the dishwasher was working again. Cook DD ran a rinse cycle on the dishwasher machine, waited for the rinse cycle, placed a pH strip in the water and it read 50 ppm. During an observation on [DATE] at 10:53 a.m., revealed Cook DD started internal temperatures for the noon meal. Cook DD cleaned the thermometer poked a foiled wrapped sweet potato thru the foil, cleaned the thermometer then poked thru the clear wrapping of the gravy, chopped pork, puree vegetables, pureed pork and pureed sweet potato. Cook DD cleaned the thermometer in between each testing of food items. During an interview on [DATE] at 11:00 a.m., the previous ADM said she expected the DM to ensure the dietary staff completed their assigned tasks. She said the DM should be monitoring and inspecting the kitchen and logs to ensure the staff completed their tasks. She said the dishwasher should never run out of solution and it risked making the residents ill. She said the facility recently worked to make improvements in the kitchen. During an interview on [DATE] at 10:03 a.m., the [NAME] President of Operations said he had done an in-service with dietary on the sanitizing levels on the dishwasher. During an interview on [DATE] at 2:00 p.m., Cook DD said she had been at the facility for almost 8 years. She said she cooked food for breakfast, lunch and sometimes dinner if staff did not show up to work. She said if staff did not come to work, she washed dishes sometimes too. She said when she worked on Fridays, she put stuff up from the delivery truck. She said food was supposed to be labeled, dated and sealed. She said food had to be labeled when opened so you knew when it expired. She said the food was not good if it was not labeled and people used expired food. She said the date let people know not to use it. She said it was very important because it could make the resident sick. She said on Monday ([DATE]), she was washing the chicken in the container, in the sink. She said she normally put frozen chicken in cold water for 30 minutes. She said she did not run the water when she thawed meat. She said stuff could not be on the floor because it could get contaminated. She said she cleaned the microwave, oven and walls but other staff made a mess and did not clean up. She said she liked a clean kitchen. She said if the dishes were dirty, they were contaminated, and resident could get sick. She said sometimes she worked alone in the kitchen, and she could not do everything. She said the Cook was responsible for the refrigerator and freezer temperature logs. She said they needed to be done every day because the food could get hot which was not good, and vegetables could get frozen which was also not good. She said she liked to poke holes in the clear wrap, so the food did not get cold. She said she did not know she could not do that. She said she did not regularly wash dishes, but solutions were needed to wash the dishes correctly. She said not having enough solution risked residents getting an infection. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Summer Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:29 p.m., Dietary Aide EE said he had been at the facility for 5 months. He said he worked 1pm-7:30pm. He said he also was the dishwasher. He said he did not work this weekend. He said the last day he worked was [DATE]. He said when he worked last, there was solution in the red bottle. He said he never changed the Chlorine solution before. He said he knew he was responsible for the red and blue solutions but did not know he was for the Chlorine solution. He said when he was hired on, Cook DD showed him how to operate the dishwasher. He said Cook DD only showed him to look at the red and blue solutions. He said he was supposed to do the PM pH strips log every day he worked. He said the dishwasher temperature should reach 120 and pH strip 50 ppm. He said no one instructed him to write the temperatures down on the log. He said he forgot to do the dishwasher log on the 20th. He said it was important to clean the dishes to take out the bacteria, so the resident did not get sick. During an interview on [DATE] at 2:45 p.m., the DM said she had been at the facility since [DATE]. She said she was responsible for making sure staff followed guidelines, mealtime schedules, diets, staff completed their duties and Cooks followed recipes. She said Cooks were responsible for labeling and dating what they opened and Dietary Aides were responsible for salads, hams and basic stuff. She said labeling, dating and sealing was important because residents could get food poison, make them sick, food given to the wrong person, or a person could get the wrong diet type or texture of food. She said on Tuesdays and Thursdays she did inventory. She said she looked through items for expiration dates, threw things away that were not labeled and dated. She said she expected raw meat to be thawed in the correct sink, container and with cold water. She said water should be running at medium speed when meat was being thawed. She said if water was not running when thawing meat, the ice would not give space for the meat to thaw. She said normally when she knew staff had chicken or beef for a meal, she tried to remind the Cooks to take it out early so it did not have to be thawed in the sink. She said if the Cooks were thawing with cold water, she temped the water and made sure it was running. She said boxes were not allowed on the floor. She said it was a trip hazard and because of cross contamination. She said she normally tried to help put things up to make sure things were not left on the floor. She said the Dietary Aide had designated area around the dishwasher to clean. The Cook was responsible for prep area. She said they took turns with other areas of the kitchen. She said the Dietary Aide was responsible for the microwave, mixer and walls. She said the Cooks were not supposed to poke holes through the clear wrap to temp the food. She said it was unsanitary to poke holes in the clear wrap. She said she never noticed Cook DD poking holes through clear wrap or foil. She said anything in the air could contaminate the food and make the food cold. She said the black metal rack was already in the kitchen when she started. She did not know if the bottom rack was 6 inches from the ground and it needed to be 6 inches from the ground so if things were wet, what was clean did not touch it. She said the morning Dietary Aides did the cooler and the Cooks did the freezer, walk-in and ice cream box. She said the temps should be done daily. She said the temps needed to be done daily because if the temps were off, food could be off or the fridge broke overnight, they would not know and the food could go bad. She said residents could get stomach bugs or GI issues. She said the Dishwasher or Dietary Aide was responsible for the dishwasher. She said she told everyone to look at the solution, check temps, and run a pH strip before using the dishwasher. She said the solution was important to clean and kill bacteria and the temperature needed to get hot enough to clean the dishes. She said dishes needed to be cleaned properly to prevent GI issues which could cause dehydration or hospitalization. She said she normally checked the dishwasher log every day. She said she did not realize the Dietary Aide was not writing down the temperatures on the log with the PPMs. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:15 p.m., the DM said Maintenance measured the black shelf and it was 5.5 inches from the ground Record review of an in-service Dietary Meeting, dated [DATE], reflected .Topic to talk to during the meeting . Labels .Cleaning list .Schedules .Deep Cleaning .Job Duties .End of Shift Duties/Sign Off Signatures noted 4 Cooks, 3 Dietary Aides and 2 Dishwashers. Record review of an in-service Label, dating, rotating, storing food correctly, dated February 2024, reflected Signatures noted for 4 Cooks and 1 Dietary Aide. Record review of an in-service Checking the Sanitizing level in the Dishwasher, dated [DATE], reflected . check the level at least once per shift using the manufacturer instructions posted on the machine . Signature noted of DM, Cook DD and Dietary Aide FF. Record review of the facility's General Kitchen Sanitation policy, dated [DATE], reflected .will maintain clean, sanitary kitchen facilities in accordance with state and US Food Codes in order to minimize the risk of infection and food borne illness .clean food contact surface .at least once a day Record review of the facility's Cleaning Schedules policy, dated [DATE], reflected .the facility will maintain a cleaning schedule .followed by employees as assigned in order to ensure that the kitchen is clean and free of hazards Record review of the facility's Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment policy, dated [DATE], indicated .the facility will follow the cleaning and sanitizing requirements of the state .for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards .chemicals added for sanitization purposes must be automatically dispensed .a test kit or other devices that accurately measures the parts per million concentration of the solution must be available and used .store all cleaned and sanitized utensils and equipment and all single-service articles at least 6 inches above the floor in a clean, dry location that protects them from contamination by splash, dust and other means. Record review of the facility's Food Storage policy, revised [DATE], reflected .to ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes .dry storage rooms .to ensure freshness, store opened and bulk items in tightly covered containers .Refrigerators .date, label and tightly seal all refrigerated foods .check the temperature of all refrigerators using the internal thermometer .temperatures should be checked each morning and again on the PM shift .record the temperature on a log that is kept near the refrigerator .Freezers .store frozen foods in moisture proof wrap or containers that are labeled and dated . temperatures should be checked each morning and again on the PM shift .record the temperature on a log that is kept near the refrigerator Record review of the facility's Food Preparation and Handling policy, revised [DATE], reflected .to ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state .thawing foods .foods may also be thawed using the following procedures . completely submerged under running water at a temperature of 70 degrees or below with sufficient water velocity to agitate and float off loosened particles (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's Food Safety in Receiving and Storage policy, dated [DATE], reflected .food will be received and stored by methods to minimize contamination and bacterial growth .when adding newly delivered food into current inventory, use the First in, First Out method so that old stock is rotated to the front and utilized first		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review, the facility failed to follow their established smoking policy regarding smoking safety for 1 of 1 resident reviewed for safe smoking. (Resident #56) The facility failed to implement Resident #56's care plan intervention to keep her electronic vape secured at the nurse's station per the facilities policy. The facility failed to implement Resident #56's care plan intervention to be supervised while smoking. The facility failed to implement Resident #56's care plan intervention to charge her electronic device with a designated staff member in non-resident areas for safety during charging per the facility's policy. These failures could place residents at risk for not receiving necessary care and services or having important care needs identified. Findings included: 1. Record review of Resident #56's face sheet dated 3/27/2024 revealed she was a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #56 had diagnoses of Charcot's joint, right ankle, and foot (a disease that attacks the bones, joints, and soft tissue of feet), Acute osteomyelitis, right ankle and foot (an infection in a bone), and Diabetes Mellitus (group of diseases that affect how the body uses blood sugar). Record review of Resident #56's quarterly MDS dated [DATE] indicated Resident #56 had a BIMS score of 13 indicating cognitively intact. Resident #56 understands and was able to be understood by others. Record review of Resident #56's comprehensive care plan with a last review date of 3/18/2024 revealed Resident #56's vape was to be kept at nurse's station. During an observation and interview on 3/27/2024 at 11:35 AM, Resident #56 said she was a smoker and kept the electronic vape on her. Resident #56 had a yellow electronic vape charging on her bed. Resident #56 said she must return her vape before dark to the nurse's station. Resident #56 said she could go outside when she wanted to go out to vape. During an interview on 3/27/2024 at 12:21 PM, CNA H said residents are not supposed to have vapes in their room and employees are to take Resident #56 out for a smoke break and said she has observed Resident #56 outside by herself vaping. During an interview on 3/27/2024 at 12:20 PM, LVN L said electronic vapes should not be kept in room and should be kept at the nurse's station after each smoke break. LVN L said residents should be monitored by staff when outside smoking. (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2024 at 10:35 AM, ADON F said he expected the nursing staff to implement the care plan. ADON F said vaping was not allowed inside the facility. ADON F said vapes should be stored on the medication cart or in the medication storage room. ADON F said vapes could overheat and become a fire hazard. During an interview on 3/28/2024 at 10:50 AM, the DON said the facility had smoke times and Resident #56 went outside with a CNA. The DON said vapes are to be stored on the medication carts and an aide would get them for the residents. The DON said the charger should be in the med cart with the vape. During an interview on 3/28/2024 at 10:57 AM, the [NAME] President of Operations said vapes should be kept on the medication cart with the charger and said electronic vapes were low risk as far as he was aware. Record review of the facility's undated smoking policy titled, Smoking Policy-Residents, indicated This facility shall establish and maintain safe resident smoking practices .to maintain a safe environment for all of their residents .smoking regulations are necessary to ensure that this is implemented and achieved in the facility . facility conducts an assessment upon admission of resident's who use vape pens .staff should monitor vape device from time-to-time, including removing from and returning to storage, for visible damage, modifications or other safety issues that may be present . charging of re-useable vape devices is not allowed in resident areas .vape pens and other vape paraphernalia are not permitted to be kept or stored in a resident's room or in their possession, all vape paraphernalia will be turned into designated staff to keep them . Limited exceptions: When ordered by a Physician and determined by resident condition and with approval of the administrator, a resident may utilize a vape pen in their room, so long as it is a private room, and the resident meets the other requirements specified above .		